

## Online Benefits Tool

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## Detail Benefits Summary

Plan: Blue Care Elect Deductible      Coverage Package Code:191121

## Plan Highlights

Benefit Features	In-Network and Out-of-Network Combined
Referral/Authorization	<a href="#">View Requirements</a>
Overall Deductible	\$3,000 per member per plan year \$7,500 per family per plan year  Deductible does not apply to in-network preventive health services, prescription drug benefits and certain other services as noted.
Out-of-Pocket Maximum	\$5,450 per member per plan year for medical benefits  \$10,900 per family per plan year for medical benefits  \$1,000 per member per plan year for prescription drug benefits  \$2,000 per family per plan year for prescription drug benefits  Calculation includes deductible, copayments and coinsurance (accumulation for medical benefits and prescription drug benefits is separate).
Overall Benefit Maximum	None

## Benefit Highlights

Services		Combined Benefit Limit	In-Network		Out-of-Network	
			Member Cost	Benefit Limit	Member Cost	Benefit Limit
<a href="#">Inpatient Medical and Surgical Care in a General Hospital</a>	Hospital services	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Physician and other covered professional provider services	None	\$0 copayment for in-person or telehealth services after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<a href="#">Inpatient Care in a Chronic Disease Hospital</a>	Hospital services	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Physician and other covered professional provider services	None	\$0 copayment for in-person or telehealth services after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<a href="#">Inpatient Care in a Rehabilitation Hospital</a>	Hospital services	60 days per calendar year	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	

	Physician and other covered professional provider services	None	\$0 copayment for in-person or telehealth services after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Inpatient Care in a Skilled Nursing Facility</u></b>	Facility services	100 days per calendar year	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Physician and other covered professional provider services	None	\$0 copayment for in-person or telehealth services after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Cardiac Rehabilitation</u></b>		None	\$15 copayment per in-person or telehealth visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Chiropractor Services</u></b>	Diagnostic lab tests and x-rays	(refer to Labs, X-Rays and Other Tests)				
	Outpatient medical care services	None	\$15 copayment per in-person or telehealth visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Dialysis Services</u></b>		None	\$0 copayment per in-person or telehealth visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Early Intervention Services</u></b>		None	\$0 copayment per in-person or telehealth visit (deductible does not apply)		amount above allowed charge (deductible and coinsurance do not apply)	
<b><u>Emergency Medical Outpatient Services</u></b>	Emergency room services	None	\$150 copayment per visit after deductible		\$150 copayment per visit after deductible	
	Office and health center services	None	\$0 copayment per in-person or telehealth visit to Virtual Care Team providers designated as primary care (deductible does not apply)  \$15 copayment per in-person or telehealth visit after deductible to other preferred providers		20% coinsurance after deductible (and amount above allowed charge)	
	Hospital outpatient medical services	None	\$15 copayment per in-person or telehealth visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Labs, X-Rays and Other Tests</u></b>	Diagnostic lab tests	None	No cost after deductible		20% coinsurance after deductible (and amount	

					above allowed charge)	
	Preoperative tests	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	MRI, CT scan, positron emission tomography and nuclear cardiac imaging tests	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Diagnostic x-rays and other imaging tests	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Other diagnostic tests	None	\$0 copayment for in-person or telehealth services after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b>Medical Care</b>						
<b><u>Outpatient Visits</u></b>						
	Office and health center services	None	\$0 copayment per in-person or telehealth visit to Virtual Care Team providers designated as primary care (deductible does not apply)  \$15 copayment per in-person or telehealth visit after deductible to other preferred providers		20% coinsurance after deductible (and amount above allowed charge)	
	Hospital services	None	\$15 copayment per in-person or telehealth visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Acupuncture services	12 visits per member per calendar year	\$15 copayment per visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Self-injectable and certain specialty drugs excluded as a medical benefit	(refer to Prescription Drugs)				
<b><u>Podiatry Care</u></b>						
	Outpatient diagnostic lab tests and x-rays	(refer to Labs, X-Rays and Other Tests)				
	Outpatient medical care services	(refer to Medical Care Outpatient Visits)				
	Outpatient surgery	(refer to Surgery as an Outpatient)				
<b><u>Radiation Therapy and Chemotherapy</u></b>						
	Office and health center services	None	\$0 copayment per in-person or telehealth visit after deductible		20% coinsurance after deductible (and amount	

					above allowed charge)	
	Hospital and free-standing radiation therapy and chemotherapy facility services	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Self-injectable and certain specialty drugs excluded as a medical benefit	(refer to Prescription Drugs)				
<b><u>Second Opinions</u></b>		(refer to Medical Care Outpatient Visits)				
<b><u>Short-Term Rehabilitation Therapy</u></b>		60 visits per member per calendar year for physical and occupational therapy (unlimited for autism)	\$15 copayment per in-person or telehealth visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Speech, Hearing and Language Disorder Treatment</u></b>	Speech therapy	None	\$15 copayment per in-person or telehealth visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Outpatient medical care services	(refer to Medical Care Outpatient Visits)				
	Diagnostic tests	(refer to Labs, X-Rays and Other Tests)				
<b><u>Surgery as an Outpatient</u></b>	Office and health center services	None	\$0 copayment per in-person or postoperative telehealth visit to Virtual Care Team providers designated as primary care (deductible does not apply)  \$15 copayment per in-person or postoperative telehealth visit after deductible to other preferred providers		20% coinsurance after deductible (and amount above allowed charge)	
	Hospital and other day surgical facility services	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Voluntary sterilization for women	None	No cost		20% coinsurance after deductible (and amount above allowed charge)	
	Removal of teeth impacted in bone		Not covered; member pays all charges		Not covered; member pays all charges	
	Self-injectable and certain specialty drugs (not part of day	(refer to Prescription Drugs)				

	surgery) excluded as a medical benefit					
<b><u>TMJ Disorder Treatment</u></b>	Outpatient medical care services	(refer to Medical Care Outpatient Visits)				
	Outpatient surgery	(refer to Surgery as an Outpatient)				
	Outpatient physical therapy	(refer to Short-Term Rehabilitation Therapy)				
	Outpatient diagnostic x-rays	(refer to Labs, X-Rays and Other Tests)				
<b><u>Maternity Services</u></b>	Inpatient physician and other covered professional provider services	None	\$0 copayment for in-person or telehealth services after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Inpatient hospital services	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Prenatal care	None	\$0 copayment per in-person or telehealth visit (deductible does not apply)		20% coinsurance after deductible (and amount above allowed charge)	
	Other maternity services	None	\$0 copayment for in-person or telehealth services after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Well Newborn Care</u></b>		None	\$0 copayment for in-person or telehealth services (deductible does not apply)		20% coinsurance (and amount above allowed charge) (deductible does not apply)	
<b><u>Infertility Services</u></b>	Outpatient medical care services	None	\$15 copayment per in-person or telehealth visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Inpatient physician and other professional provider services	None	\$0 copayment for in-person or telehealth services after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Inpatient hospital services	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Outpatient lab tests and x-rays	(refer to Labs, X-Rays and Other Tests)				
	Outpatient day surgical facility services	None	No cost after deductible		20% coinsurance after deductible (and amount	

					above allowed charge)	
	Office or health center surgery	None	\$15 copayment per in-person or postoperative telehealth visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<a href="#"><u>Mental Health and Substance Use Treatment - Biologically Based Mental Conditions</u></a>	Outpatient services	None	\$0 copayment per in-person or telehealth visit to Virtual Care Team providers (deductible does not apply)  \$15 copayment per in-person or telehealth visit after deductible to other preferred providers		20% coinsurance after deductible (and amount above allowed charge)	
	Inpatient physician and other covered professional provider services	None	\$0 copayment for in-person or telehealth services after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Inpatient facility services	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<a href="#"><u>Mental Health and Substance Use Treatment - Non-Biologically Based Mental Conditions</u></a>	Outpatient services	None	\$0 copayment per in-person or telehealth visit to Virtual Care Team providers (deductible does not apply)  \$15 copayment per in-person or telehealth visit after deductible to other preferred providers		20% coinsurance after deductible (and amount above allowed charge)	
	Inpatient physician and other covered professional provider services	None	\$0 copayment for in-person or telehealth services after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Inpatient facility services	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<a href="#"><u>Mental Health and Substance Use Treatment - Alcoholism Treatment</u></a>	Outpatient services	None	\$0 copayment per in-person or telehealth visit to Virtual Care Team providers (deductible does not apply)  \$15 copayment per in-person or telehealth visit after deductible to other preferred providers		20% coinsurance after deductible (and amount above allowed charge)	
	Inpatient physician and	None	\$0 copayment for in-person or		20% coinsurance	

	other covered professional provider services		telehealth services after deductible		after deductible (and amount above allowed charge)	
	Inpatient facility services	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Routine Pediatric Care</u></b>		according to age-based schedule	\$0 copayment per in-person or telehealth visit		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Preventive Dental Care for Children</u></b>	Preventive dental care for members under 18 to treat cleft lip and cleft palate	None	\$0 copayment per in-person or telehealth visit		20% coinsurance after deductible (and amount above allowed charge)	
	Other preventive dental care		Not covered; member pays all charges		Not covered; member pays all charges	
<b><u>Routine Adult Physical Exams</u></b>		1 exam per member per calendar year	\$0 copayment per in-person or telehealth visit		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Routine Gynecological (GYN) Exams</u></b>		1 exam per member per calendar year	No cost		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Family Planning</u></b>		None	\$0 copayment per in-person or telehealth visit		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Routine Hearing Exams and Tests</u></b>	Routine hearing exams and tests	None	\$0 copayment per in-person or telehealth visit		20% coinsurance after deductible (and amount above allowed charge)	
	Hearing aid(s)	\$2,000 per ear every 36 months (age 21 or under)	amount in excess of benefit limit		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Routine Vision Care</u></b>		1 exam per member every 24 months	No cost		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Ambulance Services</u></b>	Emergency transport	None	No cost after deductible		No cost after deductible	
	Other medically necessary transport	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Durable Medical Equipment</u></b>	Durable medical equipment	None	20% coinsurance after deductible		40% coinsurance after deductible (and amount above allowed charge)	

	Breastfeeding equipment	Refer to covered service description	No cost		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Home Health Care</u></b>		None	\$0 copayment per in-person or telehealth visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Hospice Services</u></b>		None	\$0 copayment for in-person or telehealth services after deductible		20% coinsurance after deductible (and amount above allowed charge)	
<b><u>Medical Formulas</u></b>		(refer to Prescription Drugs)				
<b><u>Oxygen and Respiratory Therapy</u></b>	Oxygen and equipment for administration	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Respiratory therapy	(refer to Medical Care Outpatient Visits)				
<b><u>Prosthetic Devices</u></b>	Ostomy supplies	None	No cost after deductible		20% coinsurance after deductible (and amount above allowed charge)	
	Other prosthetic devices	None	20% coinsurance after deductible		40% coinsurance after deductible (and amount above allowed charge)	
<b><u>Prescription Drugs</u></b>	Retail pharmacy		\$15 copayment up to a 30-day supply (Tier 1) \$30 copayment up to a 30-day supply (Tier 2) \$50 copayment up to a 30-day supply (Tier 3)	None	Not covered; member pays all charges	
	Mail order pharmacy		\$30 copayment up to a 90-day supply (Tier 1) \$60 copayment up to a 90-day supply (Tier 2) \$150 copayment up to a 90-day supply (Tier 3)	None	Not covered; member pays all charges	
	Maintenance Choice Retail pharmacy		\$30 copayment up to a 90-day supply (Tier 1) \$60 copayment up to a 90-day supply (Tier 2) \$150 copayment up to a 90-day supply (Tier 3)	None	Not covered; member pays all charges	

