Detail Benefits Summary

Plan: Blue Care Elect Deductible Coverage Package Code:196883

Plan Highlights

Benefit Features	In-Network and Out-of-Network Combined
Referral/Authorization	View Requirements
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
Inpatient Medical and Surgical Care in a General Hospital	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)	
Inpatient Care in a Chronic Disease Hospital	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)	
Inpatient Care in a Rehabilitation Hospital	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)	
Inpatient Care in a Skilled Nursing Facility	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)	
Cardiac Rehabilitation		None	$30 copayment per in-person ($20 telehealth; $10 telehealth for dependents) visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
Chiropractor Services	Diagnostic lab tests and x-rays	(refer to Labs, X-Rays and Other Tests)				
	Outpatient medical care services	None	$30 copayment per in-person ($20 telehealth; $10 telehealth for dependents) visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
Dialysis Services		None	$0 copayment per in-person or telehealth visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
Early Intervention Services		None	$0 copayment per in-person or telehealth visit (deductible does not apply)		amount above allowed charge (deductible and coinsurance do not apply)	
Emergency Medical Outpatient Services	Emergency room services	None	$150 copayment per visit after deductible		$150 copayment per visit after deductible	
	Value care office and health center services for dependent members	3 in-network zero-dollar value care visits per dependent member per plan year (includes non-emergency visits)	$0 copayment for 3 overall value care in-person or telehealth visits per dependent member per plan year includes non-emergency visits $0 copayment for 3 overall value care visits per dependent member per plan year includes non-emergency visits to designated telehealth vendor (deductible does not apply)		20% coinsurance after deductible (and amount above allowed charge)	

Other covered 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) $20 copayment per in-person or telehealth visit after deductible to other preferred family or general practitioner, pediatrician, geriatric specialist, OB/GYN physician or internist; $15 copayment ($10 telehealth) after deductible for dependent members $20 copayment per in-person or telehealth visit after deductible to other preferred nurse midwife or multi-specialty provider group; $15 copayment ($10 telehealth) after deductible for dependent members $20 copayment per in-person or telehealth visit after deductible to other preferred nurse practitioner or physician assistant designated as primary care; $15 copayment ($10 telehealth) after deductible for dependent members $30 copayment per in-person ($20 telehealth; $10 telehealth for dependents) visit after deductible to specialist, includes nurse practitioner or physician assistant designated as specialty care $20 copayment per visit after deductible to designated telehealth vendor; $10 copayment after deductible for dependent members		20% coinsurance after deductible (and amount above allowed charge)	

	Hospital outpatient medical services	None	$30 copayment per in-person ($20 telehealth; $10 telehealth for dependents) visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
Labs, X-Rays and Other Tests	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)	
Medical Care Outpatient Visits	Value care office and health center services for dependent members	3 in-network zero-dollar value care visits per dependent member per plan year (includes emergency visits)	$0 copayment for 3 overall value care in-person or telehealth visits per dependent member per plan year includes emergency visits $0 copayment for 3 overall value care visits per dependent member per plan year includes emergency visits to designated telehealth vendor (deductible does not apply)		20% coinsurance after deductible (and amount above allowed charge)	
	Other covered 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) $20 copayment per in-person or telehealth visit after deductible to other preferred family		20% coinsurance after deductible (and amount above allowed charge)	

		or general practitioner, pediatrician, geriatric specialist, OB/GYN physician or internist; $15 copayment ($10 telehealth) after deductible for dependent members $20 copayment per in-person or telehealth visit after deductible to other preferred nurse midwife or multi-specialty provider group; $15 copayment ($10 telehealth) after deductible for dependent members $20 copayment per in-person or telehealth visit after deductible to other preferred nurse practitioner or physician assistant designated as primary care; $15 copayment ($10 telehealth) after deductible for dependent members $30 copayment per in-person ($20 telehealth; $10 telehealth for dependents) visit after deductible to specialist, includes nurse practitioner or physician assistant designated as specialty care $20 copayment per visit after deductible to designated telehealth vendor; $10 copayment after deductible for dependent members			
Hospital services	None	$30 copayment per in-person ($20 telehealth; $10 telehealth for dependents) visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
Acupuncture services	12 visits per member per calendar year	$30 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)				
Podiatry Care	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)				
Radiation Therapy and Chemotherapy	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)				
Second Opinions		(refer to Medical Care Outpatient Visits)				
Short-Term Rehabilitation Therapy		60 visits per member per calendar year for physical and occupational therapy (unlimited for autism)	$30 copayment per in-person ($20 telehealth; $10 telehealth for dependents) visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
Speech, Hearing and Language Disorder Treatment	Speech therapy	None	$30 copayment per in-person ($20 telehealth; $10 telehealth for dependents) 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)				
Surgery as an Outpatient	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) $20 copayment per in-person or postoperative telehealth visit after deductible to other preferred family		20% coinsurance after deductible (and amount above allowed charge)	

			or general practitioner; $15 copayment ($10 postoperative telehealth) after deductible for dependent members $20 copayment per in-person or postoperative telehealth visit after deductible to other preferred pediatrician, geriatric specialist, OB/GYN physician or internist; $15 copayment ($10 postoperative telehealth) after deductible for dependent members $20 copayment per in-person or postoperative telehealth visit after deductible to other preferred nurse midwife or multi-specialty provider group; $15 copayment ($10 postoperative telehealth) after deductible for dependent members $20 copayment per in-person or postoperative telehealth visit after deductible to other preferred nurse practitioner or physician assistant designated as primary care; $15 copayment ($10 postoperative telehealth) after deductible for dependent members $30 copayment per in-person ($20 postoperative telehealth; $10 postoperative telehealth for dependents) visit after deductible to specialist, includes nurse practitioner or physician assistant designated as specialty care			

	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 surgery) excluded as a medical benefit	(refer to Prescription Drugs)				
TMJ Disorder Treatment	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)				
Maternity Services	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)	
Well Newborn Care		None	$0 copayment for in-person or telehealth services (deductible does not apply)		20% coinsurance (and amount above allowed charge) (deductible does not apply)	
Infertility Services	Outpatient medical care services	None	$20 copayment per in-person or telehealth visit after deductible to family or general practitioner,		20% coinsurance after deductible (and amount above allowed charge)	

		geriatric specialist, OB/ GYN physician or internist; $15 copayment ($10 telehealth) after deductible for dependent members $20 copayment per in-person or telehealth visit after deductible to nurse midwife or multi-specialty provider group; $15 copayment ($10 telehealth) after deductible for dependent members $20 copayment per in-person or telehealth visit after deductible to nurse practitioner or physician assistant designated as primary care; $15 copayment ($10 telehealth) after deductible for dependent members $30 copayment per in-person ($20 telehealth; $10 telehealth for dependents) visit after deductible to specialist, includes nurse practitioner or physician assistant designated as specialty care $30 copayment per in-person ($20 telehealth; $10 telehealth for dependents) visit after deductible for outpatient hospital medical care			
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	$20 copayment per in-person or postoperative telehealth visit after deductible to family or general practitioner; $15 copayment ($10 postoperative telehealth) after deductible for dependent members $20 copayment per in-person or postoperative telehealth visit after deductible to geriatric specialist, OB/GYN physician or internist; $15 copayment ($10 postoperative telehealth) after deductible for dependent members $20 copayment per in-person or postoperative telehealth visit after deductible to nurse midwife or multi-specialty provider group; $15 copayment ($10 postoperative telehealth) after deductible for dependent members $20 copayment per in-person or postoperative telehealth visit after deductible to nurse practitioner or physician assistant designated as primary care; $15 copayment ($10 postoperative telehealth) after deductible for dependent members $30 copayment per in-person ($20 postoperative telehealth; $10 postoperative telehealth for dependents) visit after deductible to specialist, includes nurse practitioner or physician		20% coinsurance after deductible (and amount above allowed charge)	

			assistant designated as specialty care			
Mental Health and Substance Use Treatment - Biologically Based Mental Conditions	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)	
	Value care outpatient services for dependent members	3 in-network zero-dollar value care visits per dependent member per plan year (overall mental health benefit limit)	$0 copayment for 3 overall value care in-person or telehealth visits per dependent member per plan year $0 copayment for 3 overall value care visits per dependent member per plan year to designated telehealth vendor (deductible does not apply)		20% coinsurance after deductible (and amount above allowed charge)	
	Other covered outpatient services	None	$0 copayment per in-person or telehealth visit to Virtual Care Team providers (deductible does not apply) $20 copayment per in-person or telehealth visit after deductible to other preferred providers; $15 copayment ($10 telehealth) after deductible for dependent members $20 copayment per visit after deductible to designated telehealth vendor; $10 copayment after deductible for dependent members		20% coinsurance after deductible (and amount above allowed charge)	
Mental Health and Substance Use Treatment - Non-Biologically Based Mental Conditions	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)	
	Value care outpatient	3 in-network zero-dollar	$0 copayment for 3 overall		20% coinsurance	

	services for dependent members	value care visits per dependent member per plan year (overall mental health benefit limit)	value care in-person or telehealth visits per dependent member per plan year $0 copayment for 3 overall value care visits per dependent member per plan year to designated telehealth vendor (deductible does not apply)		after deductible (and amount above allowed charge)	
	Other covered outpatient services	None	$0 copayment per in-person or telehealth visit to Virtual Care Team providers (deductible does not apply) $20 copayment per in-person or telehealth visit after deductible to other preferred providers; $15 copayment ($10 telehealth) after deductible for dependent members $20 copayment per visit after deductible to designated telehealth vendor; $10 copayment after deductible for dependent members		20% coinsurance after deductible (and amount above allowed charge)	
Mental Health and Substance Use Treatment - Alcoholism Treatment	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)	
	Value care outpatient services for dependent members	3 in-network zero-dollar value care visits per dependent member per plan year (overall mental health benefit limit)	$0 copayment for 3 overall value care in-person or telehealth visits per dependent member per plan year $0 copayment for 3 overall value care visits per dependent member per plan year to designated telehealth vendor (deductible does not apply)		20% coinsurance after deductible (and amount above allowed charge)	
		None				

	Other covered outpatient services		$0 copayment per in-person or telehealth visit to Virtual Care Team providers (deductible does not apply) $20 copayment per in-person or telehealth visit after deductible to other preferred providers; $15 copayment ($10 telehealth) after deductible for dependent members $20 copayment per visit after deductible to designated telehealth vendor; $10 copayment after deductible for dependent members		20% coinsurance after deductible (and amount above allowed charge)	
Routine Pediatric Care	Routine pediatric care	according to age-based schedule	$0 copayment per in-person or telehealth visit		20% coinsurance after deductible (and amount above allowed charge)	
	Annual mental health wellness exams	None	$0 copayment per in-person or telehealth visit		amount above allowed charge (deductible and coinsurance do not apply)	
Preventive Dental Care for Children	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	
Routine Adult Physical Exams	Routine physical exams and tests	1 exam per member per calendar year	$0 copayment per in-person or telehealth visit		20% coinsurance after deductible (and amount above allowed charge)	
	Annual mental health wellness exams	None	$0 copayment per in-person or telehealth visit		amount above allowed charge (deductible and coinsurance do not apply)	
Routine Gynecological (GYN) Exams		1 exam per member per calendar year	No cost		20% coinsurance after deductible (and amount above allowed charge)	
Family Planning		None	$0 copayment per in-person or telehealth visit		20% coinsurance after deductible (and amount above allowed charge)	
Routine Hearing Exams and Tests	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)	
Routine Vision Care		1 exam per member every 24 months	No cost		20% coinsurance after deductible (and amount above allowed charge)	
Ambulance Services	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)	
Durable Medical Equipment	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)	
Home Health Care		None	$0 copayment per in-person or telehealth visit after deductible		20% coinsurance after deductible (and amount above allowed charge)	
Hospice Services		None	$0 copayment for in-person or telehealth services after deductible		20% coinsurance after deductible (and amount above allowed charge)	
Medical Formulas		(refer to Prescription Drugs)				
Oxygen and Respiratory Therapy	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)				
Prosthetic Devices	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)	
Prescription Drugs	Retail pharmacy		$15 copayment up to a 30-day supply (Tier 1)	None	Not covered; member pays all charges	

			$30 copayment up to a 30-day supply (Tier 2) $50 copayment up to a 30-day supply (Tier 3)			
	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	