

Blue Choice - \$25 Copay Option

Plan Overview

Package ID	Default Mapping from Blue Choice Select & Blue Choice Value
Plan Name	Blue Choice - \$25 Copay Option
Plan Type	HMO
Package Status	New
Effective Date	01/01/2011
Activity Status	Active

Plan features

Primary Care Physician (PCP)	Required
Referrals	Not required
Out of network benefits	Not covered
Out of area benefits	Emergency coverage provided worldwide through the BlueCard program.
Student/Dependent coverage	Qualified dependents are covered to age 26.
Domestic partner	Covered
Wellness Incentives	Blue365 - Exclusive access to information, discounts & savings.

Plan cost-sharing highlights

Office visit copay (Primary Care Physician)	\$25 copay
Office visit copay (Specialist)	\$40 copay
Coinsurance	None
Deductible	None
Out of pocket maximum	None
Lifetime maximum	None

Plan Benefits

Preventive Healthcare Services	In-Network
Well child visits	Covered in full
Adult routine physical exams	Covered in full according to National Guidelines
+Adult immunizations	Covered in full
+Mammography	\$25 copay per visit
+Pap smear	\$25 copay per visit
Routine GYN Exam	\$25 copay per visit
Prostate cancer screening	\$25 copay per visit
Routine vision	\$40 copay for one routine exam every 2 years; every year for children to age 19. \$60 eyewear allowance every 2 years, every year to age 19
+Colonoscopy	Preventive and diagnostic covered according to the surgical benefit
Physician Office Services	In-Network
Diagnostic office visits	\$25 copay per visit to your PCP; \$40 copay per visit to a specialist
Diagnostic x-rays	\$40 copay per visit
Diagnostic laboratory and pathology	\$25 copay per visit
Allergy tests	\$25 copay per visit to your PCP; \$40 copay per visit to a specialist
Allergy injections	\$25 copay per visit to your PCP; \$40 copay per visit to a specialist
Chemotherapy	\$25 copay for IV/injectable chemotherapy, in addition to a \$25 copay for the office visit
Radiation therapy	\$25 copay per visit
Maternity Services	In-Network
Prenatal and postpartum care	\$5 copay per visit for first 10 visits, remainder of visits are covered in full
Hospital care for mom (including delivery)	Facility: Subject to \$250 copay per admission; Physician: Subject to \$200 copay or 20% coinsurance, whichever is less
Newborn nursery care	Covered in full
Prescription Drug	In-Network
Short-term and maintenance drugs	\$10/\$25/\$40
Inpatient Hospital Benefits	In-Network
Hospital benefits	Subject to \$250 copay per admission for unlimited days
Physician visits in the hospital	Covered in full

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Inpatient physical rehabilitation	Subject to \$250 copay per admission for up to 60 days per calendar year
Surgery	Facility: Subject to \$250 copay; Physician: Subject to \$200 copay or 20% coinsurance, whichever is less
Anesthesia	Covered in full
Emergency Care	In-Network
Emergency room care	\$100 copay per visit, unless admitted within 24 hours
Freestanding urgent care center	\$35 copay per visit
Ambulance	\$100 copay
Outpatient Hospital Benefits	In-Network
Diagnostic x-rays	\$40 copay per visit
Diagnostic laboratory and pathology	\$25 copay per visit
Surgical care	Facility: \$50 copay; Physician: \$40 copay
Chemotherapy	\$25 copay for IV/injectable chemotherapy, in addition to a \$25 copay for the office visit
Radiation Therapy	\$25 copay per visit
Mental Health and Chemical Dependence	In-Network
Inpatient mental health care	Subject to \$250 copay per admission for unlimited days
Outpatient mental health care	\$40 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider office.
Inpatient chemical dependence	Subject to \$250 per admission for unlimited days
Outpatient chemical dependence	\$25 copay per visit for up to 60 visits per calendar year
Other Services	In-Network
Diabetic insulin and supplies	\$25 copay for up to a 30 day supply
Skilled nursing facility	Subject to \$250 copay per admission for up to 45 days per admission; 360 days per lifetime
Home care	Covered in full for up to 40 visits per calendar year
Hospice	Subject to \$250 copay per admission for up to 210 days per lifetime
Outpatient therapy	\$40 copay per visit for up to a combined total of 30 visits per calendar year for physical, speech, occupational and respiratory therapy
Durable medical equipment	Covered at 50%
External prosthetics	Covered at 50%
Chiropractic	\$40 copay per visit
Acupuncture	Not covered
Dental	\$40 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	\$40 copay for diagnostic and routine exams. One hearing aid every 3 years to age 19

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. +Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.