HB-C-44	HealthyBlue Copay	
Plan Overview		
Package ID	HB-C-44	
Plan Name	HealthyBlue Copay	
Plan Type	PPO	
Quoting Period	01/01/2012 - 03/31/2012	
Plan features		
Primary Care Physician (PCP)	Not required	
Referrals	Not required	
Out of network benefits	Covered at 80%, subject to the deductible	
Out of area benefits	Coverage provided worldwide through the BlueCard program	
Student/Dependent coverage	Qualified dependents are covered to age 26	
Domestic partner	Covered	
Wellness Incentives	HealthyRewards - Earn up to $1,000. Blue365 - Exclusive access to information, discounts & savings	
Plan cost-sharing highlights		
Office visit copay (Primary Care Physician)	Adult: $15 copay per visit; Children to age 19: $0 copay per visit	
Office visit copay (Specialist)	$25 copay per visit	
Coinsurance	In network: Covered at 100%; Out of network: Covered at 80%	
Deductible	In network: None; Out of network: $500 Individual / $1,500 Family	
Out of pocket maximum	In network: None; Out of network $1,500 individual /$4,500 family	
Lifetime maximum	None	
Plan Benefits		
Preventive Healthcare Services	**In-Network**	**Out Of Network**
Well child visits	Covered in full	Covered in full
Adult routine physical exams	Covered in full for 1 exam per year	Covered at 80%, subject to the deductible for one routine exam per year
+Adult immunizations	Covered in full	Covered at 80%, subject to the deductible
+Mammography	Covered in full	Covered at 80%, subject to the deductible
+Pap smear	Covered in full	Covered at 80%, subject to the deductible
Routine GYN Exam	Covered in full	Covered at 80%, subject to the deductible
Prostate cancer screening	Covered in full	Covered at 80%, subject to the deductible
Routine vision	$25 copay for one routine exam every year. $60 eyewear allowance available per year	Covered at 80%, subject to the deductible for one routine exam per year. $60 eyewear allowance available per year
+Colonoscopy	Preventive screening covered in full	Covered at 80%, subject to the deductible
Physician Office Services	**In-Network**	**Out Of Network**
Diagnostic office visits	Adult: $15 copay per visit to your PCP; $25 copay per visit to a specialist. Child: $0 copay per visit to your PCP; $25 copay per visit to a specialist.	Covered at 80%, subject to the deductible
Diagnostic x-rays	$25 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered at 80%, subject to the deductible
Allergy tests	Adult: $15 copay per visit to your PCP; $25 copay per visit to a specialist. Child: $0 copay per visit to your PCP; $25 copay per visit to a specialist.	Covered at 80%, subject to the deductible
Allergy injections	Adult: $15 copay per visit to your PCP; $25 copay per visit to a specialist. Child: $0 copay per visit to your PCP; $25 copay per visit to a specialist.	Covered at 80%, subject to the deductible
Chemotherapy	$15 copay per visit	Covered at 80%, subject to the deductible
Radiation therapy	$25 copay per visit	Covered at 80%, subject to the deductible
Maternity Services	**In-Network**	**Out Of Network**
Prenatal and postpartum care	Covered in full	Covered at 80%, subject to the deductible
Hospital care for mom (including delivery)	Covered in full	Covered at 80%, subject to the deductible
Newborn nursery care	Covered in full	Covered at 80%, subject to the deductible
Prescription Drug	**In-Network**	**Out Of Network**
Short-term and maintenance drugs	$5/$25/$50; $0 copay for generics for children to age 19	Not covered

HB-C-44	HealthyBlue Copay	
Inpatient Hospital Benefits	**In-Network**	**Out Of Network**
Hospital benefits	Subject to $150 copay per admission for unlimited days	Covered at 80%, subject to the deductible
Physician visits in the hospital	Covered in full	Covered at 80%, subject to the deductible
Inpatient physical rehabilitation	Subject to $150 copay per admission for up to 60 days per year	Covered at 80%, subject to the deductible for up to 60 days per year.
Surgery	Covered in full	Covered at 80%, subject to the deductible
Anesthesia	Covered in full	Covered in full
Emergency Care	**In-Network**	**Out Of Network**
Emergency room care	$75 copay per visit, unless admitted within 24 hours	$75 copay per visit, unless admitted within 24 hours
Freestanding urgent care center	$25 copay per visit	Covered at 80%, subject to the deductible
Ambulance	$75 copay	$75 copay
Outpatient Hospital Benefits	**In-Network**	**Out Of Network**
Diagnostic x-rays	$25 copay per visit	Covered at 80%, subject to the deductible
Diagnostic laboratory and pathology	Covered in full	Covered at 80%, subject to the deductible
Surgical care	$75 copay	Covered at 80%, subject to the deductible
Chemotherapy	$15 copay per visit	Covered at 80%, subject to the deductible
Radiation Therapy	$25 copay per visit	Covered at 80%, subject to the deductible
Mental Health and Chemical Dependence	**In-Network**	**Out Of Network**
Inpatient mental health care	Subject to $150 copay per admission for up to 30 days per year	Covered at 80%, subject to the deductible for up to 30 days per year
Outpatient mental health care	$25 copay for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office.	Covered at 80%, subject to the deductible, for up to 20 visits per year. Services can be provided in an outpatient facility or in a provider office
Inpatient chemical dependence	Subject to $150 copay per admission for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime	Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per year; limited to 2 admissions per lifetime
Outpatient chemical dependence	$25 copay per visit for up to 60 visits per year	Covered at 80%, subject to the deductible for up to 60 visits per year
Other Services	**In-Network**	**Out Of Network**
Diabetic insulin and supplies	$15 copay for up to a 30 day supply	Covered at 80%, subject to the deductible for up to a 30 day supply
Skilled nursing facility	Subject to $150 copay per admission for up to 45 days per year	Covered at 80%, subject to the deductible for up to 45 days per year
Home care	Covered in full for up to 40 visits per year	Covered at 80%, subject to a $50 deductible for up to 40 visits per year.
Hospice	Covered in full for unlimited visits	Covered at 80%, subject to the deductible for unlimited visits per year
Outpatient therapy	$25 copay for up to a combined total of 45 visits per year for physical, speech and occupational therapy	Covered at 80%, subject to the deductible for a combined total of 45 visits per year for physical, speech, and occupational therapy
Durable medical equipment	Covered at 50%	Covered at 50%, subject to the deductible
External prosthetics	Covered at 50%	Covered at 50%, subject to the deductible
Chiropractic	$25 copay per visit	Covered at 80%, subject to the deductible
Acupuncture	$25 copay for up to 10 visits per year	Covered at 80%, subject to the deductible, for up to 10 visits per year
Dental	$25 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	$25 copay for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years	Covered at 80%, subject to the deductible, for one routine hearing exam per year. Hearing aid(s) covered to age 19 once every three years

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.