

Medical Benefits Options

Actives—January 2020

Product Line	HMO
Product Name	BlueChoice HMO Open Access
Services	
NETWORK	BLUECHOICE
COPAYS	\$10 PCP / \$15 Specialist copay
ANNUAL DEDUCTIBLE	
Individual	None
Family	None
ANNUAL OUT-OF-POCKET MAXIMUM	
Medical	\$2,000 Ind. / \$6,000 Family
Combined Medical and Prescription Drug	\$6,350 Ind. / \$12,700 Family
LIFETIME MAXIMUM BENEFIT	Unlimited except on fertility services
PREVENTIVE SERVICES	
Well-Child Care	
0–24 months	No charge
24 months–13 years (immunization visit)	No charge
24 months–13 years (non-immunization visit)	No charge
14–17 years	No charge
Adult Physical Examination	No charge
Routine GYN Visits	No charge
Mammograms	No charge
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge
OFFICE VISITS, LABS AND TESTING	
Office Visits for Illness	\$10 PCP / \$15 Specialist copay
Diagnostic Services	\$10 PCP / \$15 Specialist copay
X-ray and Lab Tests	No copay (LabCorp)
Allergy Testing	\$10 PCP / \$15 Specialist copay (if office visit copay paid, additional copay not required)
Allergy Shots	\$10 PCP / \$15 Specialist copay (if office visit copay paid, additional copay not required)
Outpatient Physical, Speech and Occupational Therapy (Office Setting)	\$15 copay; (limited to 30 visits combined/condition/benefit period)
Outpatient Chiropractic	\$15 copay; (limited to 20 visits/condition/benefit period)
EMERGENCY CARE AND URGENT CARE	
Physician's Office	\$10 PCP / \$15 Specialist copay
Urgent Care Center	\$10 PCP / \$15 Specialist copay
Hospital Emergency Room	\$85 copay (waived if admitted)
Ambulance (if medically necessary)	100% of AB

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HOSPITALIZATION	
Inpatient Facility Services	No charge
Outpatient Facility Services	No charge
Inpatient Physician Services	No charge
Outpatient Physician Services	\$10 PCP / \$15 Specialist copay
HOSPITAL ALTERNATIVES	
Home Health Care	No charge
Hospice	No charge
Skilled Nursing Facility (limited to 365 days/benefit period)	No charge
MATERNITY	
Preventive Prenatal and Postnatal Office Visits	No charge
Delivery and Facility Services	No charge
Nursery Care of Newborn	No charge
Artificial Insemination—Subject to State Mandate (limited to 6 attempts per live birth)	50% of the AB
InVitro Fertilization Procedures—Subject to State Mandate (limited to 3 attempts per live birth & \$100,000 lifetime max)	50% of the AB
MENTAL HEALTH (MH) AND SUBSTANCE USE DISORDER (SUD)—SUBJECT TO FEDERAL MANDATE	
Inpatient Facility Services (requires Pre-authorization)	No charge
Inpatient Physician Services	No charge
Outpatient Services (MH & SUD)	\$10 copay (office)
Partial Hospitalization	No charge
Medication Management Visit	\$10 copay
MISCELLANEOUS	
Durable Medical Equipment	No charge
Diabetic Supplies	Covered under Prescription Drug plan
Acupuncture	\$15 copay (limited to 24 visits/benefit period)
Hearing Aids for Children and Adults (limited to one hearing aid/ per ear every 36 months)	100% AB per aid/per ear; member may be balanced billed up to the total charge
Outpatient Surgery (office)	\$10 PCP / \$15 Specialist copay
Chemotherapy/Radiation Therapy (office)	\$15 copay
Renal Dialysis	No charge
Cardiac Rehab (subject to Medical Policy review)	No charge
DEPENDENT AGE LIMIT	To age 26, end of month

AB=Allowed Benefit