

# BlueCare- HMO Plan

## Schedule of Copayments Plan 15- Grandfathered

All Copayments are subject to the maximum Copayment limitations described in the Benefit Booklet. The following description of Services is not intended to create, and shall not create, any rights or obligations that differ from or are inconsistent with those set forth elsewhere in the Member Handbook.

### Out-of-Pocket

Benefit Description	Cost to Member
<b>Maximum Out-of-Pocket (per Benefit Period)</b>	
Single	\$2,000
Family	\$4,000

### Physician Services

Benefit Description	Cost to Member
<b>Primary Care Physician (PCP)</b>	\$20 Copayment
<b>Specialist</b>	\$35 Copayment
<b>In-office Surgery</b>	Subject to PCP or Specialist Copayment, whichever is applicable
<b>Allergy Injection</b>	\$0 Copayment
<b>Allergy Testing</b>	
<b>Primary Care Physician</b>	\$20 Copayment
<b>Specialist</b>	\$35 Copayment
<b>Annual Contracting Gynecologist</b>	\$35 Copayment
<b>Maternity</b> – initial obstetrician visit only	\$20 Copayment
<b>Well Child Care Services</b>	\$0 Copayment

## Inpatient Services

Benefit Description	Cost to Member
<b>Inpatient Hospital</b>	\$200 Copayment/day for day 1-5, \$1,000 maximum/Admission
<b>Inpatient Physician</b>	\$0 Copayment
<b>Inpatient Rehabilitation Services</b> (e.g., Physical, Speech, Cardiac, or Occupational)	\$0 Copayment

## Outpatient Services

Benefit Description	Cost to Member
<b>Surgical - Outpatient Hospital Surgical</b>	\$200 Copayment
<b>Surgical - Ambulatory Surgical Center</b>	\$200 Copayment
<b>Dialysis</b>	\$0 Copayment
<b>Diagnostic Lab and X-ray</b> at Hospital	\$15 Copayment
<b>Diagnostic Testing</b> at Hospital including MRI,CT Scans, Endoscopy and Stress Tests	\$200 Copayment
<b>Birthing Center</b>	\$0 Copayment

## Emergency Services and Care (\*Copayment waived if admitted)

Benefit Description	Cost to Member
<b>Emergency Room</b> in a Contracting Hospital	\$100 Copayment*
<b>Emergency Room</b> in a Non-Contracting Hospital	\$100 Copayment*
<b>Urgent Care</b> in a Contracting Urgent Care Center	\$30 Copayment
<b>Ambulance</b> (Medically Necessary)	\$0 Copayment

## Behavioral Health Services

Benefit Description	Cost to Member
<p><b>Mental Health and Substance Dependency Treatment Services</b></p> <p>Outpatient Facility Services rendered at:</p> <ul style="list-style-type: none"> <li>Emergency Room (Copayment waived if admitted)</li> <li>Contracting Hospital</li> <li>Non-Contracting Hospital</li> </ul>	<p>\$100 Copayment</p> <p>\$100 Copayment</p>
<p>Hospital</p>	<p>\$200 Copayment</p>
<p>Physician Services at a Hospital and ER</p>	<p>\$0 Copayment</p>
<p>Physician and other health care professionals licensed to perform such Services rendered at:</p> <ul style="list-style-type: none"> <li>PCP Office</li> </ul>	<p>\$20 Copayment</p>
<ul style="list-style-type: none"> <li>Contracting Specialist Office</li> </ul>	<p>\$35 Copayment</p>
<p>All other locations</p> <ul style="list-style-type: none"> <li>PCP</li> <li>Contracting Specialist</li> </ul>	<p>\$0 Copayment</p> <p>\$0 Copayment</p>
<p>Inpatient</p> <ul style="list-style-type: none"> <li>Facility Services</li> </ul>	<p>\$150 Copayment/day, \$750 maximum/Admission</p>
<p>Physician and other health care professional Services</p>	<p>\$0 Copayment</p>

## Special Services

Benefit Description	Cost to Member
<b>Bereavement Counseling</b> <b>Note:</b> \$250 or 6 visits Per Member Per Lifetime	\$0 Copayment
<b>Biofeedback</b>	\$0 Copayment
<b>Colonoscopies (Routine)</b>  Contracting Provider Non-contracting Provider	\$0 Not Covered
<b>Durable Medical Equipment</b>	\$0 Copayment
<b>Home Health Care</b> <b>Note:</b> 40 Days Per Member Per BP	\$0 Copayment
<b>Hospice Care</b>	\$0 Copayment
<b>Independent Diagnostic Testing Facility</b>  Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	\$0 Copayment
All other diagnostic Services (e.g., X-rays)	\$15 Copayment
<b>Mammograms (Routine and with diagnosis)</b>  Contracting Provider Non-Contracting Provider	\$0 Not Covered
<b>Outpatient Private Duty Nursing</b> <b>Note:</b> 40 Visits Per Member Per BP	\$0 Copayment
<b>Prosthetic &amp; Orthotic Devices</b>	\$0 Copayment
<b>Rehabilitation Services</b> (e.g., Outpatient Physical, Speech, Cardiac, or Occupational)	\$20 Copayment/visit
<b>Skilled Nursing Facility</b> 90 Days/Benefit Period	\$0 Copayment per day
<b>Second Medical Opinion</b>  Services rendered by a Contracting Provider Services rendered by a Non-Contracting Provider	\$35 Copayment 40% of Allowance

Benefit Description	Cost to Member
<b>TMJ Services</b> <b>Note:</b> 18 visits Per Member per BP	\$0 Copayment
<b>Wig</b> (after chemotherapy)	\$0 Copayment

**Benefit Maximums**

Unless specifically noted otherwise, benefit maximums apply per person and accumulate on a Benefit Period basis, as indicated below.

<b>Bereavement Counseling</b> Per Covered Plan Participant Per Lifetime .....	6 visits not to exceed a maximum of \$250
<b>Home Health Care</b> Days Per Covered Plan Participant Per BP .....	40
<b>Outpatient Private Duty Nursing</b> Visits Per Covered Plan Participant Per BP .....	40
<b>Spinal Manipulations</b> Visits Per Covered Plan Participant Per BP .....	26
<b>TMJ</b> Visits Per Covered Plan Participant Per BP .....	18
<b>Transplant Coverage for Lodging, Meals and Transportation</b> Per Covered Plan Participant Per Lifetime.....	\$10,000