Member Schedule

Benefits are available In-Network and Out-of-Network.

Employer's Name:	**Client Number:**
Client Effective Date:	**Group Number:**
Anniversary Date:	**Coverage Effective Date:**
Benefit Period:	

DEDUCTIBLE

Network Providers – $4,000 per Member per Benefit Period and **$12,000** per family per Benefit Period. With family coverage, once one Member meets a **$4,000** Deductible, benefits will begin paying for that Member.

Out-of-Network Provider – $8,000 per Member or **$24,000** per Family per Benefit Period.
The In-Network and Out-of-Network amounts do not apply to each other. The Deductible applies to the Maximum Out-of-Pocket.

The Deductible applies to all Covered Services except Preventive Care and Primary Care Physician Office visit when the Copayment applies to that visit. The Deductible applies to the Maximum Out-of-pocket.

COINSURANCE

Network Providers – The Percentage of the Allowed Amount that you pay for Covered Services. You pay **20%** of the Allowed Amount until you reach the Maximum Out-of-pocket.

Out-of-Network Providers – You pay **40%** of the Allowed Amount.

COPAYMENTS

$30 per Primary Care Physician (PCP)* Office Visit including Doctors Care

$30 per Blue CareOnDemand℠ Visit

$50 per Specialist* Office Visit

$50 per Urgent Care Center Visit

*Copayments for PCP and Specialists are In-Network only

Copayments apply toward the Maximum Out-of-pocket and stops when the Maximum Out-of-pocket is reached.

Copayments do not apply to the Deductible.

MAXIMUM OUT-OF-POCKET

Network Providers – $8,500 per Member per Benefit Period and **$17,000** per family per Benefit Period
Covered Services will be paid at 100% of the Allowable Charges when you reach your Maximum Out-of-pocket.
With family coverage, once one Member meets a **$8,500** Maximum Out-of-Pocket, benefits are payable at 100% for that Member only.

Out-of-Network Providers – $17,000 per member or **$34,000** Family per Benefit Period.

The In-Network and Out-of-Network amounts do not apply to each other. Covered Service will be paid at 100% from Network Providers after the Out-of-Pocket Limit is met.

The Maximum Out-of-pocket includes Copayments, Deductibles and Coinsurance. It does not include Premiums, Balance-billed charges or health care this Policy does not cover.

PRESCRIPTION DRUG COVERAGE

In-Network Retail: 31 days supply maximum

Tier 0: $0 Copayment
Tier 1: $8 Copayment
Tier 2: $35 Copayment
Tier 3: $70 Copayment
Tier 4: 20% up to $500 Copayment

Out-of-Network Retail:

Tier 0: No Benefits
Tier 1/2/3: In-Network Copayment then 40% coinsurance
Tier 4: No Benefits

In-Network Retail Mail-Order: 90 day supply

Tier 0: $0 Copayment
Tier 1: $16 Copayment
Tier 2: $80.50 Copayment
Tier 3: $161 Copayment
Tier 4: No Benefits

Out-of-Network Retail:

No Benefits for Out-of-Network Mail-Order pharmacy.

Some drugs are considered specialty medications and must be filled at our Specialty Pharmacy, OptumRx® Specialty Services. Although most specialty drugs are found in Tier 4, they could be Tier 1, 2 or 3. Please see your Certificate for a description of the Tiers for further clarification. Also see the Business BlueEssentials Covered Drug List for the list of drugs that must be filled with the Specialty Pharmacy.

BENEFIT PERIOD MAXIMUM — Per Member Per Benefit Period

60 days for Skilled Nursing Facility
60 visits for Home Health Care
6 months per episode for Inpatient and Outpatient Hospice Care
30 Rehabilitative visits for Physical, Speech and Occupational Therapy Services combined
30 Habilitative visits for Physical, Speech and Occupational Therapy Services combined
$500 Sustained Health Benefit for physical exam services not included in other Preventive Screenings
$500 Spinal Subluxation (Chiropractic Services) Benefit if Endorsement is purchased

All benefits payable on Covered Services are based on our allowed amount. All covered services must be medically necessary. Some services require preauthorization, including all hospital admissions, except maternity. See the preauthorization section of the Certificate for information concerning the preauthorization requirement.

For some services to be covered, you will be required to use a provider we designate, who may or may not be a Business BlueEssentials provider. These services include transplants, mammography, habilitation, rehabilitation and vision care.

Our plan has free language interpretation services available. We can also give you information in languages other than English, in large print or other alternate formats.

Services That Are Covered For You

PRIMARY CARE PHYSICIAN, SPECIALIST OR URGENT CARE CENTERS

	In-Network	Out-of-Network
Office Visit Services – All office charges for the treatment of illness, accident or injury with the exception of diagnostic services such as MRIs, MRAs, PET Scans, CT Scans, and other diagnostic scans. Includes mental health and substance use disorder services.	0% after Copayment	40% after Deductible
Blue CareOnDemand℠	0% after Copayment	40% after Deductible
Inpatient Physician and Surgical Services	20% after Deductible	40% after Deductible
All Other Physician Services – Outpatient hospital; skilled nursing facility; clinics; lab, X-ray, and the reading/interpretation of diagnostic lab and X-ray services; surgery, male sterilization; second surgical opinion; consultation; anesthesia; dialysis treatment, chemotherapy, radiation therapy and the administration of specialty medications.	20% after Deductible	40% after Deductible
Urgent Care Center – The facility must be licensed as an urgent care center.	0% after Copayment	40% after Deductible

PREVENTIVE CARE FOR CHILDREN AND ADULTS

	In-Network	Out-of-Network
As outlined in your Contract as Preventive Care benefits. Includes some contraceptive devices or services.	$0	**No Benefits**
There are No Benefits for Preventive Care Out-of-Network.		
All other covered contraceptive devices or services not specifically listed in your Contract.	20% after Deductible	40% after Deductible
Services related to a physical exam not included in other covered Preventive Screenings limited to $500 per Benefit Period. Services may be subject to age and visit limits.	$0	**No Benefits**
Services and benefits are included for Chiropractic Services limited to $500 per Benefit Period if Endorsement is purchased.	$25	**No Benefits**
There are No Benefits for Sustained Health or Chiropractic Services Out-of-Network.		

LABORATORY AND DIAGNOSTIC SERVICES

	In-Network	Out-of-Network
Radiology, ultrasound and nuclear medicine; laboratory and pathology; ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing; Endoscopies (such as colonoscopy, proctoscopy and laparoscopy); high technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans, CT scans, cardiac catheterizations and procedures performed with contrast or dye.	20% after Deductible	40% after Deductible

HOSPITAL SERVICES

	In-Network	Out-of-Network
Inpatient and outpatient Hospital (other than Skilled Nursing Facilities, Rehabilitation Facilities or Emergency Room). Includes Mental Health and Substance Use Disorder Services.	20% after Deductible	40% after Deductible
Ambulatory Surgical Center (ASC) facility charge - An ASC is a free-standing facility not affiliated with a health system that is licensed for Outpatient Services only and doesn't provide overnight accommodations or around-the-clock care.	20% after Deductible	40% after Deductible

EMERGENCY SERVICES

	In-Network	Out-of-Network
Emergency room charges in- or out-of-network or out-of-area, including physician services in the Emergency Room (copayment applies only to Emergency Room charges)	20% after Deductible	20% after Deductible
Ambulance services in- or out-of-network or out-of-area, only when medically necessary	20% after Deductible	40% after Deductible

MATERNITY

	In-Network	Out-of-Network
Pre- and post-partum care including Physician services. Hospital services provided as shown above.	20% after Deductible	40% after Deductible

Expecting a new baby? Our free Maternity Care program can provide you with the tools and information you need to help get your baby off to a healthy start. To enroll, call 855-838-5897 and select option 4.

NEWBORN CARE

	In-Network	Out-of-Network
Post-natal care, including physician services. Hospital services provided as shown above. Benefits are available only if the child is added to your policy.	20% after Deductible	40% after Deductible

REHABILITATIVE AND HABILITATIVE

	In-Network	Out-of-Network
Durable Medical Equipment (DME) - purchase or rental - excludes repair of, replacement of and duplicate DME.	20% after Deductible	**No Benefits**
There are no Out-of-Network benefits for DME		
Physical, occupational, speech and respiratory therapy	20% after Deductible	40% after Deductible
Rehabilitation including cardiac and pulmonary	20% after Deductible	40% after Deductible
Skilled nursing and rehabilitation facilities	20% after Deductible	40% after Deductible
Medical supplies	20% after Deductible	40% after Deductible

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES

	In-Network	Out-of-Network
Inpatient and physician's services	20% after Deductible	40% after Deductible
Outpatient and physician's services	20% after Deductible	40% after Deductible
Residential treatment centers	20% after Deductible	40% after Deductible
Physician's office (same as Primary Care Physician (PCP) Office visit)	0% after Copayment	40% after Deductible
Autsim Spectrum Disorder - Behavioral Therapy. Preauthorization is required	20% after Deductible	No Benefits

OTHER SERVICES

	In-Network	Out-of-Network
Dental Services Related to Accidental Injury – Only when such care is for treatment, Surgery or appliances caused by accidental bodily injury (except dental injuries occurring through the natural act of chewing). It's limited to care completed within six months of such accident and while the patient is still covered under this policy.	20% after Deductible	40% after Deductible
Home health care (60-visit maximum)	20% after Deductible	40% after Deductible
Hospice care (6 months per episode to include Inpatient and Outpatient care)	20% after Deductible	40% after Deductible
Out-of-Country services including facility and physician for emergency and urgent care only, if covered through a BlueCard® provider.	20% after Deductible	40% after Deductible