

PLAN NAME: BlueCross BlueShield BlueSaver (HMO) (2020)

Physician and other health professional services	In-Network
Primary doctor	\$15
Specialist	\$40
Radiation therapy	20%
Emergency room (waived if admitted)	\$90
Urgent care (waived if admitted)	\$65
Ambulance	\$300
Telemedicine – Doctor on Demand®	Covered in full
More than 20 preventive services	In-Network
Flu shots – Part B	Covered in full
Immunizations – Part B (hepatitis/pneumonia)	Covered in full
All other preventive screenings and tests	Covered in full
Hospital, home health care, and skilled services	In-Network
Hospital (inpatient)	\$360 per day for days 1-5, \$1,800 OOP Max per year
Observation	\$500
Outpatient surgery – hospital	\$550
Outpatient surgery – ambulatory center	\$450
Home health care	Covered in full
Skilled nursing facility (100 days per benefit period)	\$0 per day for days 1-20; \$178.00 per day for days 21-100. No yearly benefit period maximum.
Dialysis	20%
Mental health / chemical dependence services	In-Network
Mental health (inpatient, 190-day lifetime limit)	\$395 per day for days 1-4, \$1,580 OOP Max per year
Mental health (outpatient)	\$40
Mental health (with psychiatrist)	\$40
Alcohol substance abuse (inpatient)	\$395 per day for days 1-4, \$1,580 OOP Max per year

Alcohol substance abuse (outpatient)	50%
Laboratory and X-ray services	In-Network
Laboratory testing	\$10
X-rays	\$50
Advanced radiology – MRI, MRA, PET, and CT	\$200
Rehabilitation services	In-Network
Physical, occupational, and speech therapy	\$40
Chiropractor	\$20
Cardiac rehab	\$10
Vision	In-Network
Routine vision exam	\$25
Medical vision exam	\$40
Allowance (lenses and frames)	Not covered
Hearing	In-Network
Routine hearing exam – TruHearing™	\$45
Diagnostic hearing exam	\$40
Hearing aid benefit – TruHearing™	\$699/\$999
Dental	In-Network
Dental	Preventive dental (routine cleanings, oral exams & x-rays) \$10 per service
Supplies, equipment, and devices	In-Network
Durable medical equipment	\$0 compression stockings; 20% all other items
Prosthetics	\$0 diabetic shoes/inserts; 20% all other items
Diabetic supplies – Part B	Covered in full
Fitness program	In-Network
SilverSneakers® (“Steps” program included)	Covered in full
Prescription drugs – Part B	In-Network
Immunosuppressive drugs	20%
Oral chemotherapy drugs	20%
Physician administered injectables	20%
Nebulizer inhalation solution	20%
Part B drugs (other)	20%
Prescription drugs – Part D	In-Network

Prescription drug (Rx)	Preferred pharmacies: \$2/\$12/\$42/ \$94/27% Standard pharmacies: \$7/\$17/\$47/ \$100/27%
Mail order	Tier 1: \$0 copay for a 90 day supply; Tier 2 - Tier 4: 2.5 copays for a 90 day supply; Tier 5: 27% of the cost of the fill up to a 90 day supply. There is only one participating pharmacy for mail order (ESI) so there is no network.
Shingles vaccine	Preferred pharmacies: \$2 Standard pharmacies: \$7
Coverage gap/donut hole	Discounts only
General product information	In-Network
In-network out-of-pocket maximum	\$6,700
Combined out-of-pocket maximum	N/A
Prescription deductible	NON LIS Members: T 1-2: \$0, T3 - T5: \$300 LIS Members Only: LIS 1-3 Members: Tiers 1-5: \$0 LIS 4-7 Members: Tiers 1-2: \$0, Tiers 3-5 :\$89

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