

**PLAN NAME: BlueCross BlueShield Senior Blue 601 (HMO) (2020)**

<b>Physician and other health professional services</b>	<b>In-Network</b>
Primary doctor	\$10
Specialist	\$45
Radiation therapy	20%
Emergency room (waived if admitted)	\$90
Urgent care (waived if admitted)	\$65
Ambulance	\$200
Telemedicine – Doctor on Demand®	Covered in full
<b>More than 20 preventive services</b>	<b>In-Network</b>
Flu shots – Part B	Covered in full
Immunizations – Part B (hepatitis/pneumonia)	Covered in full
All other preventive screenings and tests	Covered in full
<b>Hospital, home health care, and skilled services</b>	<b>In-Network</b>
Hospital (inpatient)	\$290 per day for days 1-7, \$2,030 OOP Max per year
Observation	\$200
Outpatient surgery – hospital	\$325
Outpatient surgery – ambulatory center	\$225
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%
<b>Mental health / chemical dependence services</b>	<b>In-Network</b>
Mental health (inpatient, 190-day lifetime limit)	\$260 per day for days 1-6, \$1,560 OOP Max per year
Mental health (outpatient)	\$40
Mental health (with psychiatrist)	\$40
Alcohol substance abuse (inpatient)	\$260 per day for days 1-6, \$1,560 OOP Max per year

Alcohol substance abuse (outpatient)	50%
<b>Laboratory and X-ray services</b>	In-Network
Laboratory testing	Covered in full
X-rays	\$45
Advanced radiology – MRI, MRA, PET, and CT	\$150
<b>Rehabilitation services</b>	In-Network
Physical, occupational, and speech therapy	\$15
Chiropractor	\$20
Cardiac rehab	\$15
<b>Vision</b>	In-Network
Routine vision exam	\$25
Medical vision exam	\$45
Allowance (lenses and frames)	\$100 annual allowance
<b>Hearing</b>	In-Network
Routine hearing exam – TruHearing™	\$45
Diagnostic hearing exam	\$45
Hearing aid benefit – TruHearing™	\$699/\$999
<b>Dental</b>	In-Network
Dental	Preventive dental (routine cleanings, oral exams & x-rays) \$10 per service
<b>Supplies, equipment, and devices</b>	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
<b>Fitness program</b>	In-Network
SilverSneakers® (“Steps” program included)	Covered in full
<b>Prescription drugs – Part B</b>	In-Network
Immunosuppressive drugs	20%
Oral chemotherapy drugs	20%
Physician administered injectables	20%
Nebulizer inhalation solution	\$25
Part B drugs (other)	20%
<b>Prescription drugs – Part D</b>	In-Network

Prescription drug (Rx)	Not Covered
Mail order	Not Covered
Shingles vaccine	Not Covered
Coverage gap/donut hole	N/A
<b>General product information</b>	<b>In-Network</b>
In-network out-of-pocket maximum	\$6,700
Combined out-of-pocket maximum	N/A
Prescription deductible	N/A

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