| BENEFIT | HMO Blue New England $250 Deductible with Hospital Choice Cost Share | Blue Care Elect $250 Deductible with Hospital Choice Cost Share IN Network | Blue Care Elect $250 Deductible with Hospital Choice Cost Share Out of Network |
|---|---|---|---|
| **Deductible** | $250 Per Member<br>$750 Per Family<br>Per Plan Year | $250 Per Member Per Plan Year $750 Per Family Per Plan Year In and Out of Network Combined | |
| **Maximum Out of Pocket (MOOP)-Plan Year** | $2000/Per Member<br>$4000/Per Family for Medical Benefits Per Plan Year and<br>$2000/Per Member<br>$4000 Per Family for Prescription Drug Benefits Per Plan Year | $2000/Per Member, $4000/Per Family for Medical Benefits Per Plan Year<br>$2000/Per Member, $4000 Per Family for Rx Drug Benefits Per Plan Year<br>In and Out of Network Combined | |
| **Eligible Dependents** | Covers dependents until the end of the month in which they turn 26. | Covers dependents until the end of the month in which they turn 26. | |
| **Service Area- (check participating providers online)** | **YOU PAY** | **YOU PAY** | **YOU PAY** |
| **INPATIENT** | | | |
| **General Hospital** | $300 Per Admission AFTER Deductible at a Lower Cost Share Hospital Or<br>$700 Per Admission AFTER Deductible at a Higher Cost Share Hospital | $300 Per Admission AFTER Deductible at a Lower Cost Share Hospital<br>Or<br>$700 Per Admission AFTER Deductible at a Higher Cost Share Hospital | 20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Mental Hospital, Substance Abuse Facility (semi-private room and board and special services)** | $300 Per Admission AFTER Deductible | $300 Per Admission AFTER Deductible | 20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Physician Services, Surgical Charges, Anesthesia and Consultations.** | No Charge | No Charge | No Charge |
| **Skilled Nursing Facility** | No Charge AFTER Deductible covers up to 100 Days per Calendar Year | No Charge AFTER Deductible covers up to 100 Days per Calendar Year | 20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Rehabilitation Hospital** | No Charge AFTER Deductible, covers up to 60 Days per Calendar Year | No Charge AFTER Deductible, covers up to 60 Days per Calendar Year | 20% Coinsurance AFTER Deductible (and amount above allowed charge) |

| OUTPATIENT HOSPITAL | | | |
|---|---|---|---|
| **Emergency Room Visits for Emergency or Accident Care** | $100 Per Visit AFTER Deductible (Copayment waived if admitted or for Observation Stay) | $100 Per Visit AFTER Deductible (Copayment waived if admitted or for Observation Stay) | $100 Per Visit AFTER Deductible (Copayment waived if admitted or for Observation Stay) |
| **OutPatient Surgery** | $150 Per Admission AFTER Deductible | $150 Per Admission AFTER Deductible | 20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Radiation and Chemotherapy** | No Cost AFTER Deductible | No Cost AFTER Deductible | 20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Diagnostic X-ray & Lab** | No Cost AFTER Deductible | No Cost AFTER Deductible | 20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| | | | |
| **High Tech Radiology (MRI, CT, PT Scans)** | No Cost AFTER Deductible | No Cost AFTER Deductible | 20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Physical Therapy** | $20 Copayment Per Vist (Deductible Does NOT Apply) Up to 60 Visits per Calendar Year for PT/OT Combined | $35 Copayment Per Vist (Deductible Does NOT Apply) Up to 100 Visits per Calendar Year for PT/OT Combined | 20% Coinsurance AFTER Deductible (and amount above allowed charge) up to 100 Visits Per Calendar Year for PT/OT Combined |
| **PHYSICIAN'S OFFICE** | | | |
| **PCP OV** | $20 Copayment Per Visit (Deductible Does NOT Apply) | $20 Copayment Per Visit (Deductible Does NOT Apply) | 20%Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Specialist OV/ Acupuncture** (up to 12 Visits per Calendar Year) | $35 Copayment Per Visit (Deductible Does NOT Apply) | $35 Copayment Per Visit (Deductible Does NOT Apply) | 20%Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Mental Health Care, Substance Abuse Care** | $20 Copayment Per Visit (Deductible Does NOT Apply) | $20 Copayment Per Visit (Deductible Does NOT Apply) | 20%Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Well Child Care- up to Age 19** | No Cost | No Cost According to Age Based Schedule | 20%Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Adult Routine Physicals- Age 19 and over** | No Cost | No Cost One Exam Per Member Per Calendar Year | 20%Coinsurance AFTER Deductible (and amount above allowed charge) 1 Exam Per Member Per Calendar Year |

| | | | |
|---|---|---|---|
| **Routine GYN Exam- 1 visit per calendar year** | No Cost | No Cost<br>One Exam Per Member Per Calendar Year | 20%Coinsurance AFTER Deductible (and amount above allowed charge) 1 Exam Per Member Per Calendar Year |
| **Routine Colonoscopy (without surgery)** | No Cost | No Cost | 20%Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Routine Mammogram** | 1 Base Line Mammogram Age 35-39 and Then 1 Mammogram per Calendar Year Age 40 and Older No Cost | 1 Base Line Mammogram Age 35-39 and Then 1 Mammogram per Calendar Year Age 40 and Older No Cost | 1 Base Line Mammogram Age 35-39 and Then 1 Mammogram per Calendar Year Age 40 and Older 20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Routine Vision Exam Preventative Vision Exam** | 1 Exam per Member every 12 Months at No Cost | 1 Exam Per Member every 24 Months at No Cost | 1 Exam Per Member every 24 Months 20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| **OTHER OUTPATIENT** | | | |
| **Visiting Nurse/Home Health Care** | No Cost | No Cost AFTER Deductible | 20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Hospice Services** | No Cost | No Cost AFTER Deductible | 20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Durable Medical Equipment** | 20% Coinsurance AFTER Deductible | 20% Coinsurance AFTER Deductible | 40% Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Ambulance** (when medically necessary) | No Cost | No Cost AFTER Deductible | No Cost for Emergency Transport AFTER Deductible and 20% Coinsurance AFTER Deductible (and amount above allowed charge for Other Medically Necessary Transport |
| | | | |
| **Dental Care** | Preventative Dental Care for Members under 18 to Treat Cleft Lip and Cleft Palate Only No Cost | Preventative Dental Care for Members under 18 to Treat Cleft Lip and Cleft Palate Only<br>No Cost | Preventative Dental Care for Members under 18 to Treat Cleft Lip and Cleft Palate Only<br>20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| **Chiropractor Visits** | $35 Copay Per Visit<br>(Deductible Does NOT Apply) | $35 Copay Per Visit (Deductible Does NOT Apply) | 20% Coinsurance AFTER Deductible (and amount above allowed charge) |

| | | | |
|---|---|---|---|
| **Hearing Aids** | $2000 Per Ear Every 36 Months (Age 21 or Under Only) | $2000 Per Ear Every 36 Months (Age 21 or Under Only) | $2000 Per Ear Every 36 Months (Age 21 or Under Only)<br>20% Coinsurance AFTER Deductible (and amount above allowed charge) |
| | | | |
| **Prescription Drugs**<br>**Smart90:** 90 day supply of maintenance medications through CVS retail pharmacies | Formulary drugs:<br>Tier 1: $10 copay<br>Tier 2: $25 copay<br>Tier 3: $50 copay<br><br>Mail Order/***CVS*** :<br>Tier 1: $20 copay<br>Tier 2: $50 copay<br>Tier 3: $110 copay<br><br>30-day supply retail pharmacy or 90-day supply mail service<br><br>Non-formulary drugs: Member Pays All Charges | Formulary drugs:<br>Tier 1: $10 copay<br>Tier 2: $25 copay<br>Tier 3: $50 copay<br><br>Mail Order/***CVS*** :<br>Tier 1: $20 copay<br>Tier 2: $50 copay<br>Tier 3: $110 copay<br><br>30-day supply retail pharmacy or 90-day supply mail service<br><br>Non-formulary drugs: Member Pays All Charges | Not Covered, Member Pays ALL Charges |
| **OTHER BENEFITS** | | | |
| **Fitness Benefit/Special Programs (See Plan for Details)** | $150 Reimbursement Per Calendar Year Per Policy | $150 Reimbursement Per Calendar Year Per Policy | |
| **Weight Loss/Special Programs (See Plan for Details)** | $150 Reimbursement Per Calendar Year Per Policy | $150 Reimbursement Per Calendar Year Per Policy | |