BlueCare® Direct Simplicity Overview

Offered through First Priority Life Insurance Company®

BlueCross of Northeastern Pennsylvania
Independent Licensee of the Blue Cross and Blue Shield Association
® Registered Mark of the Blue Cross and Blue Shield Association

Our plans cover a full spectrum of health care services—just about everything you'll need. **Deductibles, coinsurance and copays are what you pay out of your pocket.** All deductible and coinsurance amounts are based on "allowable charges." These are the negotiated rates that Blue Cross of Northeastern Pennsylvania will accept as a reasonable charge for care and that preferred providers will accept as payment in full. Deductible and/or coinsurance will apply unless otherwise noted as "Not subject to deductible or coinsurance," "Copay" or "Covered 100%."

Overall Costs	Tier 1	Tier 2
Benefit Period	Calendar Year	
Deductible The amount you pay before your coverage will pay for services	$500 / $750	$2,000
Coinsurance The amount you pay after the deductible is met	20%	40%
Out-of-Pocket Maximum (Includes deductible) The maximum amount you could pay for covered services in any calendar year	$4,000	$5,000

Benefit Outline		
Preventive Care *Please refer to the "BlueCare Preventive Package" for a complete list of covered preventive benefits.*		
Adult Preventive Exams & Immunizations	Covered 100%	Subject to deductible & coinsurance
Childhood Preventive Exams & Immunizations	Covered 100%	Subject to coinsurance only Not subject to deductible
Gynecological Services Includes exam, Pap test and clinical breast exam	Covered 100%	Subject to coinsurance only Not subject to deductible
Routine Mammography Eligible once per calendar year and when physician recommended	Covered 100%	Subject to coinsurance only Not subject to deductible
Colorectal Cancer Screenings	Covered 100%	Subject to deductible & coinsurance
Nutritional Counseling Limited to 6 visits per calendar year	Covered 100%	Subject to deductible & coinsurance
Prenatal Care	Covered 100%	Subject to deductible & coinsurance
Prostate Screenings	Covered 100%	Subject to deductible & coinsurance
Bone Density Screenings	Covered 100%	Subject to deductible & coinsurance

Prescription Drugs		
Deductible	None	N/A
Retail *30-day supply*	Tier 1: $8 copay Tier 2: $45 copay Tier 3: $95 copay Specialty: 25% coinsurance with $200 maximum per drug, per fill	Not covered
Mail-Order *90-day supply*	Tier 1: $16 copay Tier 2: $90 copay Tier 3: $190 copay Specialty: Not covered through mail-order	Not covered

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Outpatient Services		
Basic Diagnostic Testing	$25 copay Per type, per day	Subject to deductible & coinsurance
Advanced Imaging (MRI, MRA, Cat Scan, Pet Scan and Nuclear Cardiology)	$150 copay Per type, per day	Subject to deductible & coinsurance
Office Visits	Primary Care: $35 copay Specialist: $50 copay	Subject to deductible & coinsurance
Therapy **Physical therapy:** 15 visits per calendar year **Occupational therapy & speech therapy:** 15 combined visits per calendar year **Chiropractic care:** 10 visits per calendar	$50 copay	Subject to deductible & coinsurance
Radiation and Chemotherapy	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Dialysis	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Diagnostic Mammography	Covered 100%	Subject to coinsurance only Not subject to deductible
Diagnostic Prostate Screening	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Mental Health & Substance Abuse	Not covered	Not covered

Emergency Services		
Emergency Room	$150 copayment	$150 copayment
Emergency Ambulance	Subject to deductible & coinsurance	Subject to **Tier 1** deductible & coinsurance

Inpatient Services		
Inpatient Hospital	$500 copay per admission, then Subject to deductible & coinsurance	$500 copay per admission, then Subject to deductible & coinsurance 90 days per calendar year
Skilled Nursing Limited to 100 days per calendar year	$500 copay per admission, then Subject to deductible & coinsurance	$500 copay per admission, then Subject to deductible & coinsurance
Mental Health	Not covered	Not covered
Substance Abuse	Not covered	Not covered

Other Services		
Allergy Extracts/Injections	$25 copay per day	Subject to deductible & coinsurance
Home Health Care Limited to 100 visits per calendar year	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Home Infusion	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Durable Medical Equipment	Subject to deductible & coinsurance	Not covered
Hospice Care Limited to 180 days per lifetime	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Maternity	Subject to deductible & coinsurance	Subject to deductible & coinsurance
Non-emergency Ambulance $3,000 maximum per calendar year	Subject to deductible & coinsurance	Subject to deductible & coinsurance

BlueCare individual plans do not cover "pre-existing conditions." This means that if you have received medical advice or treatment for any condition, disease, ailment or injury within the last 5 years, we will not cover treatment for that condition until you have been enrolled in a BlueCare plan for 12 months. This does not apply to children under age 19 or HIPAA eligible individuals.