



New Blue Care Network HMO

Preventive services	
Health maintenance exam	Covered - \$20 copay
Annual gynecological exam	
Pap smear screening – lab only (American Cancer Society guidelines apply)	
Well-baby and well-child care	
Immunizations	Covered – 100%
Infertility counseling and treatment (excluding in-vitro fertilization)	Covered - \$20 copay
Mammography	
Mammography screening	Covered - 100%
Physician office services	
Office visits	Covered - \$20 copay
Consulting specialist care – when referred	
Emergency medical care	
Hospital emergency room	Covered - \$200 copay (waived if admitted for inpatient stay)
Physician's office	Covered - \$20 copay
Urgent care center	Covered - \$20 copay or 50% of treatment costs, whichever is less
Ambulance services – when medically necessary	Covered – 100% ground and air
Diagnostic services	
Laboratory and pathology tests	Covered – 100%
Diagnostic tests and X-rays	
Radiation therapy	
Maternity services provided by a physician	
Pre-natal and Post-natal care	Covered – \$20 copay per visit
Delivery and nursery care	Covered - 100%
Hospital care	
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies	Covered – 100%, unlimited days
Inpatient consultations	Covered – 100%
Chemotherapy	
Alternatives to hospital care	
Skilled nursing care	Covered – 100%; limited to 730 days
Hospice care	Covered – 100%
Home health care	Covered – 100% in facility; \$20 office visit for each home visit
Surgical services	
Surgery – includes related surgical services and anesthesia	Covered – 100%
Voluntary sterilization	
Human organ transplants	Covered – 100%, in designated facilities and/or subject to medical criteria
Mental health care and substance abuse treatment	
Inpatient mental health and substance abuse care	Covered – 100% when authorized by BCN
Outpatient mental health care per calendar year	
Outpatient substance abuse care	
Other services	
Allergy testing and therapy	Covered – 100%
Chiropractic spinal manipulation when referred by PCP	Covered - \$20 copay
Outpatient physical, speech and occupational therapy	Covered – 100%, 60-day treatments/medical episode year, \$20 copay for each visit
Durable medical equipment	Covered – 100%
Prosthetic and orthotic appliances	Covered – 100%
Vision and hearing screenings – when performed in physician's office	Covered – 100%; office visit copay may apply
Prescription drugs – includes contraceptives	<ul style="list-style-type: none"> • Retail pharmacy copays: \$10-Generic/\$30 - Brand name preferred/\$60 – Brand name non-preferred • Mail order pharmacy copays: \$20 - Generic /\$60-Brand name preferred/\$120 – Brand name non-preferred
Deductible, copays and out-of-pocket dollar maximum	
Deductible and out-of-pocket dollar maximums	None
Copays	<ul style="list-style-type: none"> • \$20 - Office visits and urgent care center services • \$200 - Emergency room services (waived if admitted) • Retail pharmacy prescription drug: \$10 - Generic/\$30 –Brand name preferred/\$60 – Brand name non-preferred • Mail order pharmacy prescription drug: \$20 - Generic /\$60 – Brand name preferred/\$120 – Brand name non-preferred