



Blue Care® IPA \$15/\$25 80

Calendar Year Deductibles

Individual None
 Family None
 Calendar Year Coinsurance Limit : Individual/Family \$8,000/\$16,000

Preventive Medical Services

In Network Benefits

• Periodic Physical Exams	Covered at 100%
• Routine Annual GYN Exam	Covered at 100%
• Routine Mammogram	Covered at 100%
• Routine Sigmoidoscopy & Colonoscopy	Covered at 100%
• Routine Pap Smear	Covered at 100%
• Routine Well-Child Care	Covered at 100%
• Immunizations	Covered at 100%
• Routine Vision Exams	Covered at 100%
• Routine Hearing Exams	Covered at 100%
• Prostate Screening Antigen Test	Covered at 100%
• Lead Poisoning Screening Test	Covered at 100%

Treatment of Illness or Injury

In Network Benefits

• Primary Doctor's Office Visits for Diagnosis & Treatment	\$15 copay per visit
• Specialist/Referral Care	\$25 copay per visit
• Laboratory Services <ul style="list-style-type: none"> o Independent o Hospital based 	\$10 copay per visit \$50 copay per visit
• Imaging & Machine Testing Services <ul style="list-style-type: none"> o Independent o Hospital based 	\$25 copay per visit \$50 copay per visit
• OP High Tech Radiology Independent and Hospital Based (e.g. MRI, MRA, CT, PET scan)	\$150 copay per visit
• Chiropractic (up to 30 visits per calendar year)	Covered at 80%
• Physical & Occupational Therapy (30 visits combined per calendar year)	\$25 copay per visit
• Speech Therapy (30 visits per calendar year)	\$25 copay per visit
• Radiation Therapy and Chemotherapy	\$25 copay per visit
• Inpatient Hospital <ul style="list-style-type: none"> o Semiprivate Room (including intensive care, if medically necessary) o Physician's & Surgeon's Services o Other Medical Professional Services (including maternity) 	Covered at 80% Covered at 80% Covered at 80%
• Outpatient Surgical Facility <ul style="list-style-type: none"> o Outpatient Ambulatory o Outpatient Hospital 	Covered at 100% Covered at 80%

Emergency Services

In Network Benefits

• Emergency Room	Covered at 80%
• Urgent Care Centers / Medical Aid Units	\$25 copay per visit
• Ambulance	Covered at 80%

Other Services

In Network Benefits

• Inpatient Private Duty Nursing (up to 240 hours per 12 month period)	Covered at 80%
• Durable Medical Equipment (DME)	Covered at 75%
• Skilled Nursing Facility (up to 120 visits per confinement)	Covered at 80%
• Home Health Care (up to 100 visits per calendar year)	Covered at 80%
• Alcohol and Substance Abuse Treatment ¹	Covered same as medical
• Serious Mental Health Care ¹	Covered same as medical
• Other Mental Health Care	
o Inpatient and Partial Hospitalization (up to 31 inpatient days or 62 partial hospitalization days per calendar year. Two partial hospitalization days reduce inpatient days by one day. One inpatient day reduces partial hospitalization days by two days.	Covered at 60%
o Outpatient (up to 20 visits per calendar year)	\$25 copay per visit

Prescription Drugs

• Prescription Drugs	See “Your Prescription Drug Program”
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¹Delaware law defines serious mental illness as including nine diagnostic classes. Benefits for serious mental illness and substance abuse treatment are covered at the same levels as other medical care.

Your PCP must authorize your health care services. Most medical services are provided in the offices of panel physicians.

Note: Copays still apply after coinsurance expense limit has been reached.

Note: The plan includes reduced coverage for bariatric surgeries and preferred coverage for organ transplants performed at the Blue Distinction Centers for Transplants (BDCT). For transplants performed at participating but non-BDCT facilities, charges are covered at a reduced benefit level. Transplants performed at non-participating facilities are not covered.

This Benefits Summary presents plan highlights only. It is not a contract. Please refer to your benefits booklet (or contact your marketing representative to request a copy) for complete information.

All percentages are based on BCBSD's allowable charge.

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