BluePreferred Summary of Benefits

(Benefit period)		
(Members are responsible for applicable physician and facility fees)		

Services	In-network You Pay[1,2]	Out-of-network You Pay[1,3]
Home Health Care (limited to 90 visits per episode of care)	Deductible, then 15% of Allowed Benef t	Deductible, then 25% of Allowed Benef t
Hospice (Inpatient—limited to maximum 180 day Hospice eligibility period; Outpatient—limited to 60 days per Hospice eligibility period)	Deductible, then 15% of Allowed Benef t	Deductible, then 25% of Allowed Benef t
Skilled Nursing Facility (limited to 60 days/benef t period)	Deductible, then 15% of Allowed Benef t	Deductible, then 25% of Allowed Benef t
Preventive Prenatal and Postnatal O f ce Visits	No charge*	Deductible, then 25% of Allowed Benef t
Delivery and Facility Services	Deductible, then 15% of Allowed Benef t	Deductible, then 25% of Allowed Benef t
Nursery Care of Newborn	Deductible, then 15% of Allowed Benef t	Deductible, then 25% of Allowed Benef t
Arti f cial and Intrauterine Insemination (limited to six (6) attempts per live birth)	Deductible, then 50% of Allowed Benef t	Not covered
Assisted Reproductive Technology[7] (limited to three (3) attempts per live birth; and a lifetime maximum benef t of $100,000)	Deductible, then 50% of Allowed Benef t	Not covered
	(Members are responsible for applicable physician and facility fees)	
Inpatient Facility Services	Deductible, then 15% of Allowed Benef t	Deductible, then 25% of Allowed Benef t
Inpatient Physician Services	Deductible, then 15% of Allowed Benef t	Deductible, then 25% of Allowed Benef t
Outpatient Facility Services	No charge*	Deductible, then 25% of Allowed Benef t
Outpatient Physician Services	No charge*	Deductible, then 25% of Allowed Benef t
O f ce Visits	$15 per visit	Deductible, then 25% of Allowed Benef t