

# Medical Coverage Details

Did You Know?

You can compare estimated annual medical expenses for these plans with the Medical Expense Estimator.

- ↓ [Summary of Benefits and Coverage](#)
- ↓ [Plan Facts](#)
- ↓ [Annual Cost](#)
- ↓ [Coverage](#)

## Summary of Benefits and Coverage

	Blue Cross and Blue Shield HRA
Coverage Details	<a href="#">2025 Blue Cross and Blue Shield HRA</a> (PDF, 37 KB)

↑ [Top](#)

## Plan Facts

Plan Facts	Blue Cross and Blue Shield HRA
Carrier name	Blue Cross and Blue Shield
Member services phone number	1-877-324-2990

Plan Facts	Blue Cross and Blue Shield HRA
Web site	<a href="http://bullseyehealthspot.com">bullseyehealthspot.com</a>
Need to file claims	<b>In Network</b> No; Submitted by providers  <b>Out of Network</b> Yes
Ability to self-refer to OB/GYN	Yes
Ability to self-refer to specialists	Yes

[↑ Top](#)

## Annual Cost

Plan Prices	Blue Cross and Blue Shield HRA
TM Only	Not Applicable
TM+Spouse/DP	Not Applicable
TM+Child(ren)	4049.28
TM+Family	Not Applicable
Account-Based Plans--Account Information	Blue Cross and Blue Shield HRA
HRA--Team member only	\$500: Engage in healthy actions to earn \$500 through the Well-being Rewards Program. Complete activities by March 31

Account-Based Plans--Account Information	Blue Cross and Blue Shield HRA
HRA--Team member and spouse/domestic partner	\$1,000: Engage in healthy actions to earn \$1,000 through the Well-being Rewards Program. Complete activities by March 31
HRA--Team member and child	\$650: Engage in healthy actions to earn \$650 through the Well-being Rewards Program. Complete activities by March 31
HRA--Team member and family	\$1,000: Engage in healthy actions to earn \$1,000 through the Well-being Rewards Program. Complete activities by March 31
Eligible expenses for reimbursement	All plan covered expenses. Does not include pharmacy copays
HRA Web site	<a href="https://bullseyehealthspot.com">bullseyehealthspot.com</a>
Expenses paid via spending account apply to deductible	Yes
HSA-Employer amount: TM only(doesn't apply to COBRA)	Not applicable
HSA-Employer amount: TM and spouse(doesn't apply to COBRA)	Not applicable
HSA-Employer amount: TM and child(doesn't apply to COBRA)	Not applicable

Account-Based Plans--Account Information	Blue Cross and Blue Shield HRA
HSA-Employer amount: TM and family(doesn't apply to COBRA)	Not applicable
General Medical Expenses	Blue Cross and Blue Shield HRA
Under family cov, does individual ded apply, i.e., embedded?	Yes
Annual deductible: Team member/Family	<b>In Network</b> \$1,150 Team Member; \$2,500 Team Member + Spouse; \$1,800 Team Member + Child(ren); \$2,550 Family  <b>Out of Network</b> \$2,250 Team Member; \$4,400 Team Member + Spouse; \$3,650 Team Member + Child(ren); \$4,750 Family
Primary doctor office visit	<b>In Network</b> 80% covered after deductible is met  <b>Out of Network</b> 50% covered after deductible is met
Specialist office visit	<b>In Network</b> 80% covered after deductible is met  <b>Out of Network</b> 50% covered after deductible is met

General Medical Expenses	Blue Cross and Blue Shield HRA
Out-of-pocket maximum: Team member/Family	<b>In Network</b> \$3,900 TM; \$7,300 TM + Spouse; \$5,900 TM + Child(ren); \$8,100 Family; includes deductible. (An individual out-of-pocket maximum of \$7150 applies)  <b>Out of Network</b> \$8,400 Team Member; \$15,100 Team Member + Spouse; \$12,750 Team Member + Child(ren); \$17,100 Family; includes deductible
Lifetime coverage limit	<b>In Network</b> Limit does not apply  <b>Out of Network</b> Limit does not apply
Coinsurance percentage	<b>In Network</b> 80% covered until out-of-pocket maximum is met  <b>Out of Network</b> 50% covered until out-of-pocket maximum is met
Inpatient Hospital Care	Blue Cross and Blue Shield HRA

Inpatient Hospital Care	Blue Cross and Blue Shield HRA
Hospital	<b>In Network</b> 80% covered; after plan deductible  <b>Out of Network</b> 50% covered; after plan deductible
Hospital semi-private room	<b>In Network</b> 80% covered after plan deductible  <b>Out of Network</b> 50% covered after plan deductible
Inpatient physician and surgeon services	<b>In Network</b> 80% covered after deductible is met, COE usage through lantern required for spinal and bariatric surgery; 100% covered  <b>Out of Network</b> 50% covered after deductible is met
Inpatient lab and X-ray	<b>In Network</b> 80% covered after deductible is met  <b>Out of Network</b> 50% covered after deductible is met
Outpatient Care	Blue Cross and Blue Shield HRA

Outpatient Care	Blue Cross and Blue Shield HRA
Outpatient surgery	<b>In Network</b> 80% covered after deductible is met, COE usage through lantern required for spinal and bariatric surgery; 100% covered  <b>Out of Network</b> 50% covered after deductible is met
Outpatient laboratory services	<b>In Network</b> 80% covered after deductible is met  <b>Out of Network</b> 50% covered after deductible is met
Outpatient X-ray	<b>In Network</b> 80% covered after deductible is met  <b>Out of Network</b> 50% covered after deductible is met
Emergency room (not followed by admission)	<b>In Network</b> 80% covered after deductible is met; for medical emergencies  <b>Out of Network</b> 80% covered after deductible is met; for medical emergencies

Outpatient Care	Blue Cross and Blue Shield HRA
Urgent care clinic visit	<b>In Network</b> 80% covered after deductible is met  <b>Out of Network</b> 50% covered after deductible is met
Ambulance services	80% covered after deductible is met; Non-emergency: covered at 50% after deductible is met
Durable medical equipment	<b>In Network</b> 80% covered after deductible is met, preauthorization required for items costing more than \$1,500  <b>Out of Network</b> 50% covered after deductible is met; preauthorization required for items costing more than \$1,500
Other medications considered preventive under HC Reform	<b>In Network</b> Check with pharmacy plan administrator;  <b>Out of Network</b> Not covered.
Prescription Drug Expenses	Blue Cross and Blue Shield HRA
Prescription drug vendor	Express Scripts (ESI)



Prescription Drug Expenses	Blue Cross and Blue Shield HRA
Prescription drug Web site	<a href="https://bullseyehealthspot.com">bullseyehealthspot.com</a>
Prescription drug member services phone number	1-877-324-2990
Rx subject to overall medical deductible & OOP	No
Rx subject to overall medical OOP max only (not medical ded)	Check with Plan
Does Rx deductible apply to medical OOP max?	Check with Plan
Annual prescription deductible	<b>In Network</b> Not applicable  <b>Out of Network</b> Not applicable
Annual prescription maximum benefit	<b>In Network</b> Not applicable  <b>Out of Network</b> Check with Plan
Annual prescription out-of-pocket maximum	<b>In Network</b> Copays apply to the medical out-of-pocket maximum  <b>Out of Network</b> Not applicable
Retail generic	<b>In Network</b> Up to \$8 copay; 34 day supply; \$20 copay; 90 day supply at CVS/Caremark retail  <b>Out of Network</b> Not covered

Prescription Drug Expenses	Blue Cross and Blue Shield HRA
Retail preferred brand	<b>In Network</b> Up to \$42 copay; 34 day supply; Up to \$105 copay; 90 day supply at CVS/Caremark retail  <b>Out of Network</b> Not covered
Retail non-preferred brand	<b>In Network</b> Up to \$90 copay; 34 day supply; Up to \$225 copay; 90 day supply at CVS/Caremark Retail  <b>Out of Network</b> Not covered
Retail Specialty	<b>In Network</b> \$0 copay if enrolled in SaveOn, otherwise 30% coinsurance  <b>Out of Network</b> Not covered
Mail order generic	Up to \$20 copay; 90 day supply
Mail order preferred brand	Up to \$105 copay; 90 day supply
Mail order non-preferred brand	Up to \$225 copay; 90 day supply
Mail order specialty	Not covered.

Prescription Drug Expenses	Blue Cross and Blue Shield HRA
Telehealth	<b>In Network</b> Telemedicine/Virtual Visit: 100% covered (Dr. On Demand and CirrusMD)  <b>Out of Network</b> Check with Plan
Telemental Health	<b>In Network</b> all visits at no cost for each enrolled member  <b>Out of Network</b> Check with Plan
Virtual physical therapy	<b>In Network</b> 100% coverage through Hinge Health  <b>Out of Network</b> No Covered
Annual deductible for an individual with family coverage	<b>In Network</b> Check with Plan  <b>Out of Network</b> Check with Plan
Under family coverage, does individual out-of-pocket maximum	Yes
Annual out-of-pocket maximum for an individual with family	<b>In Network</b> \$7,150  <b>Out of Network</b> No

↑ [Top](#)

## Coverage

Preventive Care	Blue Cross and Blue Shield HRA
Annual physical exam	<b>In Network</b> 100% covered; limited to one exam per year  <b>Out of Network</b> 50% covered after deductible is met; limited to one exam per year
Well-woman exam (includes pap)	<b>In Network</b> 100% covered; limited to one exam per year  <b>Out of Network</b> 50% covered after deductible is met
Pediatric exams	<b>In Network</b> 100% covered  <b>Out of Network</b> 50% covered after deductible is met
Immunizations (child)	<b>In Network</b> 100% covered  <b>Out of Network</b> 50% covered after deductible is met

---

Preventive CareBlue Cross and Blue Shield HRA

---

## Mammogram

**In Network**

100% covered;  
covered for age 35 and  
older

**Out of Network**

50% covered after  
deductible is met;  
covered for age 35 and  
older

---

Routine vision exams**In EyeMed Network**

Vision Exam Plan: In  
Network - \$0 copay  
and limited to one  
exam every 12 months  
for ages 19 and up;  
covered at 100% for  
ages 0-18; check with  
EyeMed for details

**Out of Network**

Team member pays  
full cost of exam.  
EyeMed will reimburse  
up to \$35: Limited to  
once every 12 months  
for ages 19+, No visit  
limit on exams for ages  
0-18. Check with  
EyeMed for details.

---

Preventive Care	Blue Cross and Blue Shield HRA
Regular lenses and frames	<p><b>In EyeMed Network</b> Optional coverage at additional cost; \$10 copay for standard lenses every 12 mths; frames covered up to \$175, 20% discount off remainder, every 12 mths: contact EyeMed for details</p> <p><b>Out of Network</b> Contact EyeMed for details</p>
Contact lenses	<p><b>In EyeMed Network</b> Optional coverage at additional cost; 100% covered up to \$175 every 12 months; \$0 copay for standard fit plus f/u exam; cannot combine with frames allowance; contact EyeMed for details</p> <p><b>Out of Network</b> Contact EyeMed for details</p>
Vision plan member services phone number	1-855-653-6226
Vision plan Web site	<a href="https://eyemedvisioncare.com/target">eyemedvisioncare.com/target</a>
Maternity Care	Blue Cross and Blue Shield HRA

Maternity Care	Blue Cross and Blue Shield HRA
Office visit: Pre/postnatal	<b>In Network</b> 100% covered; postnatal is covered 80% after deductible  <b>Out of Network</b> 50% covered after deductible is met
In-hospital delivery services	<b>In Network</b> 80% covered after deductible is met  <b>Out of Network</b> 50% covered after deductible is met
Doula	<b>In Network</b> \$2,000 per pregnancy through a certified doula. Plan accumulators apply.  <b>Out of Network</b> \$2,000 per pregnancy through a certified doula. Plan accumulators apply.
Fertility	<b>In Network</b> 2 cycle lifetime medical and pharmacy limit through Progyny. Plan accumulators apply  <b>Out of Network</b> Not covered
Mental Health and Substance Abuse Care	Blue Cross and Blue Shield HRA

Mental Health and Substance Abuse Care	Blue Cross and Blue Shield HRA
Mental Health: Outpatient coverage	<b>In Network</b> 80% covered after deductible is met  <b>Out of Network</b> 50% covered after deductible is met
Mental Health: Inpatient coverage	<b>In Network</b> 80% covered after deductible is met  <b>Out of Network</b> 50% covered after deductible is met
Detox: Outpatient coverage	<b>In Network</b> 80% covered after deductible is met  <b>Out of Network</b> 50% covered after deductible is met
Detox: Inpatient coverage	<b>In Network</b> 100% covered  <b>Out of Network</b> 50% covered after deductible is met
Rehab: Outpatient coverage	<b>In Network</b> 80% covered after deductible is met  <b>Out of Network</b> 50% covered after deductible is met



Mental Health and Substance Abuse Care	Blue Cross and Blue Shield HRA
Rehab: Inpatient coverage	<b>In Network</b> 100% covered  <b>Out of Network</b> 50% covered after deductible is met
Medical Therapy	Blue Cross and Blue Shield HRA
Chiropractic	<b>In Network</b> 80% covered after deductible is met; limited to 24 visits per year  <b>Out of Network</b> 50% covered after deductible is met; limited to 24 visits per year
Acupuncture	<b>In Network</b> 80% covered after deductible is met; limited to 24 visits per year  <b>Out of Network</b> 80% covered after deductible is met; limited to 24 visits per year

↑ [Top](#)

The comparison charts are compiled using information that applies to a large number of health plan users and is commonly reported by the health plans. Depending on the chart type, such as charts for dental and vision plans, certain information and/or sections won't appear because the necessary data isn't available. In addition, the charts may not take into account how each plan covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance on the benefits offered by the plan. If you have questions about a topic that isn't covered in the charts, contact the plan's member services department for additional information. Neither Target nor Alight Solutions is responsible for the accuracy of this information. If

there is a discrepancy between the information displayed on these charts and the official plan documents, the official plan documents will control. Target reserves the right to amend, suspend, or terminate the plan(s) or program(s) at any time.