BluePPO H vs Blue Cross/Blue Shield Classic Blue Coverage

BENEFIT COMPARISON – BROOME BOCES

TYPE OF SERVICE	BLUEPPO- Plan H IN NETWORK	 OUT OF NETWORK	Classic Blue Traditional Indemnity
Deductible	None	Individual: $250 Family: $750	$100/$300 Deductible (Family = 3 Individual)
Lifetime Maximum	Unlimited		Unlimited
Out of Pocket Maximum ***(Includes deductibles and coinsurance)***	None	Individual: $1,000 Family: $3,000	$400 per person/per year (excluding deductible) (Family = 3 Individual)
PHYSICIAN SERVICES	**Coinsurance – None**	**Coinsurance: 20%**	
Office visits	$10 co-pay per visit	deductible + coinsurance	Subject to deductible + 20% coinsurance
Well Child Services: **$ Periodic Health Exams** **$ Immunizations**	100% of allowable amount ages 0-19	100% of allowable amount ages 0-19	! Paid-in-full ages 0-19
Allergy Testing	Office co-pay per visit	deductible + coinsurance	Subject to deductible + 20% coinsurance
Allergy Treatments	Covered in Full	deductible + coinsurance	Subject to deductible + 20% coinsurance
Chiropractic Services	Office co-pay per visit	deductible + coinsurance	Subject to deductible + 20% coinsurance
OUTPATIENT SERVICES			
Outpatient Surgeons Fee	$10 copayment	deductible + coinsurance	! Paid-in-full
Outpatient Physical Therapy	$10 Copayment Inpatient Physical Therapy – Covered in Full	deductible + coinsurance	Subject to deductible + 20% coinsurance
Occupational or Speech Therapy	Covered in full	deductible + coinsurance	Subject to deductible + 20% coinsurance
Diagnostic and Treatment Services ((Lab testing & X-ray)	$10 copayment	deductible + coinsurance	Paid-in-full if rendered in outpatient hospital setting and/or providers office

EMERGENCY SERVICES			
Emergency Room Care	$50 copayment per visit	deductible + coinsurance	Covered In Full when medical emergency or accidental injury
Ambulance	$10 copayment	deductible + Coinsurance	Covered in Full if admitted or emergency OP
HOSPITAL SERVICES			
Days of Room and Board in Semi-Private Room	Covered in Full (unlimited days)	deductible + coinsurance	Covered in Full (unlimited days)
Inpatient Surgery (Surgeon=s Fee)	Covered in Full	deductible + coinsurance	! Paid-in-full
Anesthesia	Covered-in-full	deductible + 20% coinsurance	! Paid-in-full
Inpatient Skilled Nursing Facility (SNF)	Covered-in-full up to 120 days per SNF stay - 90 day renewal	Deductible + coinsurance up to 120 days per SNF stay - 90 day renewal	! Paid-in-full
WOMENS HEALTH AND MATERNITY CARE			
Mammography / Pap Test	Covered-in full	deductible + coinsurance	! Paid-in-full
Initial Pregnancy Consultation	Office co-pay	deductible + coinsurance	Subject to deductible + 20% coinsurance
Prenatal/ Postpartum Services	Covered-in full	deductible + coinsurance	! Paid-in-full
Child Birth Education Classes	No benefit	No benefit	No benefit
Delivery (Physicians charge)	Covered-in full	deductible + coinsurance	! Paid-in-full
Hospital Services	Covered-in full	deductible + coinsurance	! Paid-in-full
Birthing Center	Covered-in full	deductible + coinsurance	! Paid-in-full
Newborn Inpatient Care	Covered-in full	deductible + coinsurance	Paid-in-full - family policy only

MENTAL HEALTH, ALCOHOLISM, AND SUBSTANCE ABUSE TREATMENT SERVICES			
Acute Outpatient Mental Health Treatment	Same as office visit benefit	Same as office visit benefit	Same as office visit benefit
Acute Outpatient Alcohol or Substance Abuse Treatment Services	Covered-in-full	deductible + coinsurance	! Paid-in-full - 60 visits per calendar year Additional days may be available
Acute Inpatient Treatment, Alcohol, or Substance Abuse Rehabilitation Services	Covered in Full	deductible + coinsurance	Benefit equal to In-Patient Hospital coverage
Acute Inpatient Mental/Nervous Conditions	Covered in Full - 30 days per year	deductible + coinsurance	Benefit equal to In-Patient Hospital coverage
OTHER HEALTH SERVICES			
Home Health Care Services	Covered in Full - unlimited visits	deductible + coinsurance	! 60 visits Blue Cross Plus 325 additional visits
Hospice Services	Covered -in-full - unlimited days	deductible + coinsurance	! Paid-in-full up to 210 days
Durable Medical Equipment	20% Coinsurance	deductible + coinsurance	Subject to deductible and 20% coinsurance
Prosthetic Devices ($15,000 Calendar Year Maximum)	20% Coinsurance	deductible + coinsurance	Subject to deductible and 20% coinsurance No Calendar year Maximum
Elective Sterilization	Office copay	deductible + coinsurance	Covered in Full
Diabetic Services and Equipment	Office copay per item	deductible + coinsurance	Covered in Full
Routine Physical	Office copay	deductible + coinsurance	Covered in full – 1 Adult per year
PRESCRIPTION DRUGS			
Retail & Mail-Order	$5 Tier 1/$15 Tier 2/$30 Tier 3 Mail order $15/$45/$90 (90 day supply – copay is for 3 monthly scripts) **Subject to preferred drug list**		$5 Tier 1/$15 Tier 2/$30 Tier 3 – one copay for 90 day fill on all tiers. Local pharmacy or mail order

o You are responsible for the difference between charges and the BCBS allowable amount

! Our allowance is accepted as payment-in-full when services are rendered by a BlueCross BlueShield participating provider

**** Pre-Authorization Required on All Inpatient admissions, home health, infusion therapy, DME over $200, MRI, CAT and PET scans for Blue PPO Program.**

Please note: This is an outline of benefits only. Complete info will be in the group benefit contract(s). Benefits are subject to medical necessity as determined by carrier.