

# BluePPO vs BlueCross BlueShield REGIONWIDE Coverage

## BENEFIT COMPARISON

TYPE OF SERVICE	BLUEPPO- Plan H		BLUECROSS BLUESHIELD REGIONWIDE PLAN
	IN NETWORK	OUT OF NETWORK	
<b>Deductible</b>	None	Individual: \$250 Family: \$750	\$75 Major Medical (Family = 3 Individual)
<b>Lifetime Maximum</b>	Unlimited		\$1,000,000 Major Medical
<b>Out of Pocket Maximum</b> <i>(Includes deductibles and coinsurance)</i>	None	Individual: \$1,000 Family: \$3,000	Major Medical - \$400 per person/per year (excluding deductible)
<b>PHYSICIAN SERVICES</b>	<b>Coinsurance – None</b>	<b>Coinsurance: 20%</b>	
<b>Office visits</b>	\$10 co-pay per visit	deductible + coinsurance	Subject to deductible + 20% coinsurance
<b>Well Child Services: \$ Periodic Health Exams \$ Immunizations</b>	100% of allowable amount ages 0-19	100% of allowable amount ages 0-19	! Paid-in-full ages 0-19
<b>Allergy Testing</b>	Office co-pay per visit	deductible + coinsurance	Subject to deductible + 20% coinsurance
<b>Allergy Treatments</b>	Covered in Full	deductible + coinsurance	Subject to deductible + 20% coinsurance
<b>Chiropractic Services</b>	Office co-pay per visit	deductible + coinsurance	Subject to deductible + 20% coinsurance
<b>OUTPATIENT SERVICES</b>			
<b>Outpatient Surgeons Fee</b>	\$10 copayment	deductible + coinsurance	! Paid-in-full
<b>Outpatient Physical Therapy</b>	Covered -in-full	deductible + coinsurance	Paid-in-full when rendered in outpatient hospital setting Subject to deductible + 20% coinsurance when rendered in provider office
<b>Occupational or Speech Therapy</b>	Covered in full	deductible + coinsurance	Considered part of Home Health Care benefit only. Limited Speech Therapy benefit under Major Medical. Please consult contract.
<b>Diagnostic and Treatment Services ((Lab testing &amp; X-ray)</b>	\$10 copayment	deductible + coinsurance	Paid-in-full if rendered in outpatient hospital setting and/or providers office

<b>EMERGENCY SERVICES</b>			
<b>Emergency Room Care</b>	\$50 copayment per visit	deductible + coinsurance	Covered In Full when medical emergency or accidental injury
<b>Ambulance</b>	\$10 copayment	deductible + Coinsurance	Covered in Full if admitted or emergency outpatient
<b>HOSPITAL SERVICES</b>			
<b>Days of Room and Board in Semi-Private Room</b>	Covered in Full (unlimited days)	deductible + coinsurance	! 365 days -additional days under Major Medical
<b>Inpatient Surgery (Surgeon=s Fee)</b>	Covered in Full	deductible + coinsurance	! Paid-in-full
<b>Anesthesia</b>	Covered-in-full	deductible + 20% coinsurance	! Paid-in-full
<b>Inpatient Skilled Nursing Facility (SNF)</b>	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
<b>WOMENS HEALTH AND MATERNITY CARE</b>			
<b>Mammography / Pap Test</b>	Covered-in full	deductible + coinsurance	! Paid-in-full
<b>Initial Pregnancy Consultation</b>	Office co-pay	deductible + coinsurance	Subject to deductible + 20% coinsurance
<b>Prenatal/ Postpartum Services</b>	Covered-in full	deductible + coinsurance	! Paid-in-full
<b>Child Birth Education Classes</b>	No benefit	No benefit	No benefit
<b>Delivery (Physicians charge)</b>	Covered-in full	deductible + coinsurance	! Paid-in-full
<b>Hospital Services</b>	Covered-in full	deductible + coinsurance	! Paid-in-full
<b>Birthing Center</b>	Covered-in full	deductible + coinsurance	! Paid-in-full
<b>Newborn Inpatient Care</b>	Covered-in full	deductible + coinsurance	Paid-in-full - family policy only

<b>MENTAL HEALTH, ALCOHOLISM, AND SUBSTANCE ABUSE TREATMENT SERVICES</b>			
<b>Acute Outpatient Mental Health Treatment</b>	50% copayment – 20 visits per calendar year	Subject to deductible – 50% for 20 visits per calendar year	Subject to deductible - 80% for 30 visits per calendar year.
<b>Acute Outpatient Alcohol or Substance Abuse Treatment Services</b>	Covered-in-full (up to 60 visits per calendar year)	deductible + coinsurance (up to 60 visits per calendar year)	! Paid-in-full - 60 visits per calendar year
<b>Acute Inpatient Treatment, Alcohol, or Substance Abuse Rehabilitation Services</b>	Covered in Full- 37 days (2 admissions per lifetime)	deductible + coinsurance	Acute Inpatient Care – Covered in Full Approved Residential Facility – 28 days covered at 80% under MM
<b>Acute Inpatient Mental/Nervous Conditions</b>	Covered in Full - 30 days per year	deductible + coinsurance	Covered under basic Blue Cross
<b>OTHER HEALTH SERVICES</b>			
<b>Home Health Care Services</b>	Covered in Full - unlimited visits	deductible + coinsurance	! 40 visits Blue Cross 325 additional visits under Major Medical
<b>Hospice Services</b>	Covered -in-full - unlimited days	deductible + coinsurance	! Paid-in-full up to 210 days
<b>Durable Medical Equipment</b>	20% Coinsurance	deductible + coinsurance	Subject to deductible and 20% coinsurance
<b>Prosthetic Devices (\$15,000 Calendar Year Maximum)</b>	20% Coinsurance	deductible + coinsurance	Subject to deductible and 20% coinsurance
<b>Elective Sterilization</b>	Office copay	deductible + coinsurance	Covered in Full
<b>Diabetic Services and Equipment</b>	Office copay per item	deductible + coinsurance	Subject to deductible and 20% coinsurance
<b>Routine Physical</b>	Office copay	deductible + coinsurance	\$50 for an annual physical for an active employee over age 50
<b>PRESCRIPTION DRUGS</b>			
<b>Retail &amp; Mail-Order</b>	\$5/\$15/\$30  <b>Subject to preferred drug list</b>		Major Medical Rx (deductible/coinsurance)

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 BluePPO 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.