Le Moyne College Benefit Comparison 2013

BluePPO Option J:

In-Network – Care rendered by a participating BlueCross BlueShield PPO provider. No PCP referral required. Out-Network- Care rendered by a non-participating BlueCross BlueShield provider.

Healthy Blue:

In-Network – Care rendered by a participating BlueCross BlueShield PPO provider. No PCP referral required. Out-Network- Care rendered by a non-participating BlueCross BlueShield provider.

Benefit Category		BluePPO		HealthyBlue
Preventive Health Care Service	ces:			
Well Child Visits	In-Network Out-Network	Covered in full Covered in full	In-Network Out-Network	Covered in full Covered in full
Adult Routine Physical Exam (1 per year)	In-Network Out-Network	Covered in full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	Covered in full Covered, subject to deductible and 40% coinsurance
Adult Immunizations	In-Network Out-Network	Covered in full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	Covered in full Covered, subject to deductible and 40% coinsurance
Pap Smear and Mammography	In-Network Out-Network	Covered in full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	Covered in full Covered, subject to deductible and 40% coinsurance
Routine GYN Exams	In-Network Out-Network	Covered in full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	Covered in full Covered, subject to deductible and 40% coinsurance
Prostate Cancer Screening	In-Network Out-Network	Covered in full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	Covered in full Covered, subject to deductible and 40% coinsurance
Routine Vision Care (1 per year)	Not covered		In-Network Out-Network	\$40 Copay Covered, subject to deductible and 40% coinsurance
Colonoscopy	In-Network Out-Network	Preventive: Covered in full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	Preventive: Covered in full Covered, subject to deductible and 40% coinsurance
Physician Office Services:				
Diagnostic Office Visits	In-Network	\$20 Copay	In-Network	\$25 Copay for PCP; \$40 Copay for Specialist; \$0 Copay for child to age 19 for PCP;
	Out-Network	Covered, subject to deductible and 30% coinsurance	Out-Network	\$40 Copay for Specialist Covered, subject to deductible and 40% coinsurance
Diagnostic x-ray Services	In-Network Out-Network	\$20 Copay* Covered, subject to deductible and 30% coinsurance*	In-Network Out-Network	\$40 Copay Covered, subject to deductible and 40% coinsurance
	*Precertifica	tion applies to MRI, PET, & CAT so	cans	
Diagnostic Laboratory and Pathology Services	In-Network Out-Network	Covered in Full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	Covered in Full Covered, subject to deductible and 40% coinsurance

Benefit Category		BluePPO		HealthyBlue
Allergy Tests	In-Network	\$20 Copay	In-Network	\$25 Copay for PCP; \$40 Copay for Specialist; \$0 Copay for child to age 19 for PCP; \$40 Copay for Specialist
	Out-Network	Covered, subject to deductible and 30% coinsurance	Out-Network	Covered, subject to deductible and 40% coinsurance
Allergy Injections	In-Network	\$20 Copay	In-Network	\$25 Copay for PCP; \$40 Copay for Specialist; \$0 Copay for child to age 19 for PCP; \$40 Copay for Specialist
	Out-Network	Covered, subject to deductible and 30% coinsurance	Out-Network	Covered, subject to deductible and 40% coinsurance
Chemotherapy	In-Network Out-Network	Covered in full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	\$25 Copay Covered, subject to deductible and 40% coinsurance
Radiation Therapy	In-Network Out-Network	Covered in full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	\$40 Copay Covered, subject to deductible and 40% coinsurance
Maternity:				
Prenatal & Postpartum care	In-Network	\$20 Copay for 1 st visit, Remainder of visits covered in full	In-Network	Covered, subject to deductible and 20% coinsurance
	Out-Network	Covered, subject to deductible and 30% coinsurance	Out-Network	Covered, subject to deductible and 40% coinsurance
Hospital Care for Mother (including delivery)	In-Network	Hospital & Delivery covered in Full	In-Network	Covered, subject to deductible and 20% coinsurance
	Out-Network	Covered, subject to deductible and 30% coinsurance	Out-Network	Covered, subject to deductible and 40% coinsurance
Newborn Nursery Care	In-Network Out-Network	Covered in Full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	Covered in Full Covered, subject to deductible and 40% coinsurance
Prescription Drugs:				
Short term and maintenance drugs	Retail (30 day	v supply):	Retail (30 day	/ supply):

Short term and maintenance drugs are covered up to a 30-day supply at participating retail pharmacies;	Retail (30 day supply): Tier 1 - \$10 Copay Tier 1 Tier 2 - \$30 Copay Tier 2 Tier 3 - \$50 Copay Tier 3	Retail (30 day supply): Tier 1 - \$5 Copay (\$0 Copay for generics for child to age 19) Tier 2 - \$35 Copay Tier 3 - \$70 Copay
90-day supply (subject to the copays per 90-day supply) is available through PrimeMail mail order pharmacy	n Tier 1 - \$20 Copay Tier 2 - \$60 Copay	Mail order (90 day supply): Tier 1 - \$10 Copay (\$0 Copay for generics for child to age 19) Tier 2 - \$70 Copay
	Tier 3 - \$100 Copay	Tier 3 - \$140 Copay

Should a doctor choose a brand-name drug when an FDA-approved generic equivalent is available, the benefit will be based on the generic drug's cost and the member will have to pay the difference, plus any applicable Copay. If a brand-name prescription has no approved generic equivalent, the benefit won't be affected.

Inpatient Hospital Services:				
Hospital Benefits	In-Network	Covered in Full for unlimited days*	In-Network	Covered, subject to deductible and 20% coinsurance
	Out-Network	Covered, subject to deductible and 30% coinsurance*	Out-Network	Covered, subject to deductible and 40% coinsurance
	*Precertifica			40% comsurance
Physician visits in the hospital	In-Network	Covered in Full	In-Network	Covered, subject to deductible and 20% coinsurance
	Out-Network	Covered, subject to deductible and 30% coinsurance	Out-Network	Covered, subject to deductible and 40% coinsurance
Inpatient physical rehabilitation (up to 60 days per calendar year)	In-Network	Covered in Full	In-Network	Covered, subject to deductible and 20% coinsurance
(up to 66 days per emendar year)	Out-Network	Covered, subject to deductible and 30% coinsurance*	Out-Network	Covered, subject to deductible and 40% coinsurance
	*Precertifica	tion applies		
Surgery	In-Network	Covered in Full	In-Network	Covered, subject to deductible and 20% coinsurance
	Out-Network	Covered, subject to deductible and 30% coinsurance	Out-Network	Covered, subject to deductible and 40% coinsurance
Anesthesia	In-Network	Covered in Full	In-Network	Covered, subject to deductible and 20% coinsurance
	Out-Network	Covered, subject to deductible and 30% coinsurance	Out-Network	Covered, subject to deductible and 20% coinsurance
Emergency Services:				
Emergency Room Care	In-Network Out-Network	\$50 Copay* \$50 Copay* *Unless admitted within 24		\$250 Copay* \$250 Copay*
Freestanding Urgent Care Center	In-Network Out-Network	\$25 Copay Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	\$40 Copay Covered, subject to deductible and 40% coinsurance
Ambulance	In-Network Out-Network	\$20 Copay \$20 Copay	In-Network Out-Network	\$250 Copay \$250 Copay
Outpatient Hospital Benefits:				
Diagnostic x-ray Services	In-Network Out-Network	\$20 Copay* Covered, subject to deductible and 30% coinsurance*	In-Network Out-Network	\$40 Copay Covered, subject to deductible and 40% coinsurance
	*Precertifica	tion applies to MRI, PET, & CAT sc	ans	40% comsurance
Diagnostic Laboratory and Pathology Services	In-Network Out-Network	Covered in Full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	Covered in Full Covered, subject to deductible and 40% coinsurance
Surgical Care	In-Network	\$20 Copay	In-Network	Covered, subject to deductible and 20% coinsurance
	Out-Network	Covered, subject to deductible and 30% coinsurance	Out-Network	Covered, subject to deductible and 40% coinsurance
Chemotherapy	In-Network Out-Network	Covered in full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	\$25 Copay Covered, subject to deductible and 40% coinsurance

Benefit Category		BluePPO		HealthyBlue	
Radiation Therapy	In-Network Out-Network	Covered in full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	\$40 Copay Covered, subject to deductible and 40% coinsurance	
Mental Health & Chemical De	pendence:				
Inpatient Mental Health Care	In-Network	Covered in Full for unlimited days*	In-Network	Covered, subject to deductible and 20% coinsurance	
		Covered, subject to deductible and 30% coinsurance*	Out-Network	Covered, subject to deductible and 40% coinsurance	
	*Precertifica	tion applies			
Outpatient Mental Health Care	In-Network Out-Network	\$20 Copay* Covered, subject to deductible and 30% coinsurance*	In-Network Out-Network	\$40 Copay* Covered, subject to deductible and 40% coinsurance*	
	*!	Services can be provided in an outpat	tient facility or	in a provider office	
Inpatient Chemical Dependence	In-Network	Covered in Full for unlimited days*	In-Network	Covered, subject to deductible and 20% coinsurance	
		Covered, subject to deductible and 30% coinsurance*	Out-Network	Covered, subject to deductible and 40% coinsurance	
	*Precertifica	tion applies			
Outpatient Chemical Dependence	In-Network Out-Network	\$20 Copay Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	\$40 Copay Covered, subject to deductible and 40% coinsurance	
Other Services:					
Diabetic Insulin & Supplies (up to a 30-day supply)	In-Network Out-Network	\$20 Copay Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	\$25 Copay Covered, subject to deductible and 40% coinsurance	
Skilled Nursing Facility	In-Network	Covered in Full*	In-Network	Covered, subject to deductible and 20% coinsurance	
		Covered, subject to deductible and 30% coinsurance (Up to 120 days)*	Out-Network	Covered, subject to deductible and 40% coinsurance (Up to 45 days)	
	*Precertifica	tion applies			
Home Care	In-Network	Covered in Full*	In-Network	Covered, subject to deductible and 20% coinsurance*	
		Covered, subject to \$50 deductible and 25% coinsurance*		Covered, subject to \$50 deductible and 25% coinsurance*	
	*Precertification applies. Unlimited visits.				
Hospice Care (unlimited days)	In-Network Out-Network	Covered in Full Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	Covered in Full Covered, subject to deductible and 40% coinsurance	
Outpatient Therapy	In-Network Out-Network	\$20 Copay* Covered, subject to deductible and 30% coinsurance*	In-Network Out-Network	\$40 Copay* Covered, subject to deductible and 40% coinsurance*	
	*Up to a combined total of 45 visits per calendar year for physical, speech, respiratory, occupational therapy.				
Durable Medical Equipment	In-Network	Covered, subject to deductible and 20% coinsurance*	In-Network	Covered, subject to deductible and 20% coinsurance	
		Covered, subject to deductible and 30% coinsurance*	Out-Network	Covered, subject to deductible and 40% coinsurance	
	*Precertifica	tion applies			

Benefit Category		BluePPO		HealthyBlue
External Prosthetics	In-Network	Covered, subject to deductible and	In-Network	Covered, subject to deductible and
	Out-Network	20% coinsurance Covered, subject to deductible and 30% coinsurance	Out-Network	20% coinsurance Covered, subject to deductible and 40% coinsurance
Chiropractic Care	In-Network Out-Network	\$20 Copay Covered, subject to deductible and 30% coinsurance	In-Network Out-Network	\$40 Copay Covered, subject to deductible and 40% coinsurance
Acupuncture	In-Network Out-Network	Not covered Not covered	In-Network Out-Network *Up to 10 vis	\$40 Copay* Covered, subject to deductible and 40% coinsurance*
Dental		\$20 Copay* Covered, subject to deductible and 30% coinsurance* atal injury to sound, natural teeth and	In-Network Out-Network	\$40 Copay* Covered, subject to deductible and 40% coinsurance*
Hearing	In-Network	Routine exams not covered Routine exams not covered	In-Network Out-Network	\$40 Copay* Covered, subject to deductible and 40% coinsurance* atine hearing exam per year
HealthyRewards Earn cash back	N/A		cash back for	up to \$500 individually, or a combined \$1,000 r you and your spouse just for doing healthy stuff your day. Then get paid anytime throughout
Calendar Year Deductible	In-Network Out-Network	None \$750 Individual/\$2,250 Family	Combined In-Network and Out-Network: \$250 Individual/ \$750 Family	
Coinsurance	In-Network Out-Network	None 30%	In-Network Out-Network	20% 40%
Annual Out of Pocket Maximum (Includes Deductibles and Coinsurances; does <u>not</u> include copayments)	In-Network Out-Network	None \$2,000 Individual/\$6,000 Family	Combined In-Network and Out-Network: \$750 Individual/ \$2,250 Family	
Lifetime Maximum	Unlimited		Unlimited	
Dependent Coverage	Covers spous students to ag	e and qualified dependents and te 26	Covers spous students to ag	e and qualified dependents and e 26

This outline of benefits is for illustrative purposes, only. Official benefits, limitations and exclusions contained in actual contract.