BETHLEHEM CSD
2009-10 BENEFIT COMPARISON

	CDPHP EPO $15	BSNENY PPO 813 (Secure Blue)		BSNENY TB 907 (Par Plus-Indemnity)
		In-Network	Out-of-Network	*Not available to Active BCUEA employees
TYPE OF PLAN	An Exclusive Provider Organization (EPO) with no coverage for non-participating providers, except in a medical emergency. Allows direct access to ALL participating providers. No specialist referrals are required.	A Preferred Provider Organization (PPO). Coverage varies based on whether services are provided by an in-network or out-of-network provider. No Primary Care Physician, and no specialist referrals required. Prior approval required for some benefits.		An indemnity product offering coverage through both participating and non-participating providers. No Primary Care Physician, and no specialist referrals required.
ANNUAL DEDUCTIBLE	None	None	$250 individual, $500 family	Additional Benefits: $250 Individual/$500 Family
CO-INSURANCE	None	None	20% coinsurance based on schedule of allowances	Additional Benefits: 80% UCR Coverage; Hospital & Medical Services: 100% Coverage
OUT-OF-POCKET LIMIT	None	None	Coinsurance waived after member has spent $2500 Ind/$5000 Family in a calendar year, excluding payments in excess of the Schedule of Allowances.	Coinsurance waived after Blue Shield has paid $5,000 (member out-of-pocket: $1250)
MAXIMUM LIFETIME PAYMENTS	None	None	No lifetime maximum; $250,000 annual maximum per individual	Additional Benefits: $1,000,000 per subscriber
DEPENDENT COVERAGE	Dependents to age 19 Full-Time Students to age 25	Dependents to age 19 - Full-Time Students to age 25		Dependents to age 19 - Full-Time Students to age 25
WAITING PERIOD	None	None		None
HOSPITAL SERVICES				
Inpatient	Covered in full	Covered in full	Deductible and 80% of fee schedule	Covered in full up to 365 days per hospital admission
Outpatient	$15 copay	Covered in full	Deductible and 80% of fee schedule	Covered in full
Emergency Room	$50 copay *(waived if admitted)*	$35 copay *(waived if admitted)*		Covered in full
MENTAL HEALTH				
In-patient	Covered in full up to 60 days per benefit period	Covered in full, up to 30 days per calendar year *(aggregate)*	Deductible and 80% of fee schedule, up to 30 days per calendar year *(aggregate)*	Covered in full up to 120 days.

Out-patient	$15 copay - up to 20 visits per benefit period	Up to 30 annual visits; $15 copay	Deductible and 80% of fee schedule, 30 visits annually *(aggregate)*	Deductible and 80% of usual & customary up to 25 visits.
SUBSTANCE ABUSE				
In-patient	Covered in full	Covered in full, up to 7 days per year hospital for detox/30 days rehab	7 days per year hospital for detox/30 days rehab, deductible & 80% of fee schedule	Covered in full, up to 7 days per year hospital for detox/30 days rehab.
Out-patient	$15 copay up to 60 visits per calendar year	$15 copay, up to 60-visits per calendar year *(aggregate)*	Deductible and 80% of fee schedule, up to 60-visits per calendar year *(aggregate)*	Covered in full up to 60 visits per yar
PHYSICIAN SERVICES				
Office Visits	$15 copay	$15 copay	Deductible and 80% of fee schedule	Deductible and 80% of usual and customary.
Hospital Visits	Covered in full	Covered in full	Deductible and 80% of fee schedule	Covered in full, one visit per day up to 365 days per single confinement.
Surgery	Covered in full	Covered in full	Deductible and 80% of fee schedule	Covered in full.
Second Opinion	$15 copay	$15 copay	Deductible and 80% of fee schedule	Covered in full.
Annual Physical	Covered in full (one per calendar year)	$15 copay	Not covered	Members 50 years or older: one routine physical per 12-month period up to $50.
OTHER SERVICES				
HOME HEALTH CARE	Covered in full w/ preauthorization	$15 copay, up to 100-visits per year *(aggregate)*	Deductible and 80% of fee schedule up to 100-visits epr year *(aggregate)*	Covered in full.
HOSPICE	Covered in full up to 210 days per member lifetime	Covered in full up to 210 days.	Deductible and 80% of fee schedule up to 210 days.	Covered in full up to 210 days.
WELL BABY CARE & IMMUNIZATIONS	Covered in full through age 19	Covered in full, 0 thru 18 years of age	Deductible and 80% of fee schedule, 0 thru 18 years of age	Through age 19, covered in full with participating provider; deductible and 80% of usual and customary for non-participating provider.

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LAB & X-RAY	Hospital: covered in full; Lab: $15 copay *(waived if provider is preferred or a designated radiology/lab network provider)*	Covered in full	Deductible and 80% of fee schedule	Covered up to 100% fee schedule. Amount over par allowance paid at 80% up to usual & customary, subject to deductible.
AMBULANCE	$50 copay	Covered in full	Deductible and 80% of fee schedule	Covered up to $60.
DURABLE MEDICAL EQUIPMENT	20% coinsurance w/ preauthorization	80% of fee schedule	Deductible and 50% of fee schedule or charges, whichever is lower	Covered in full through par providers. Non-par providers paid at 80% of usual and customary, subject to deductible.
PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	$15 copay (Physical/Occupational to 120 days each, per diagnosis. Speech to 60 visits per diagnosis.	$15 copay; up to 60-visits per year *(aggregate)*	Deductible and 80% of fee schedule, up to 60-visits per year *(aggregate)*	Deductible and 80% of usual and customary.
PRESCRIPTION DRUGS	Express Scripts, Inc. $5/15/30 Retail $10/30/60 Mail Order	Express Scripts, Inc. $5/15/30 Retail $10/30/60 Mail Order		Express Scripts, Inc. $5/15/30 Retail $10/30/60 Mail Order
VISION CARE	$15 copay, 1 exam every 24 months	$15 copay; one exam annually for children 14 & under; one exam every two years for over age 14	Not covered	Not covered
PREVENTIVE DENTAL CARE FOR CHILDREN	Not covered	Not covered	Not covered	Not covered

PLEASE NOTE:

This information is intended only as a summary comparison of benefits and is not intended as a contract. For more detailed information concerning benefits, limitations, and exclusions, please refer to the actual contract. All visit limits are an aggregate between in and out-of-network services.