

PPO Product Comparison



Webster University

Benefit	Blue Cross Current		Anthem New		Change
	Network	Non-Network	Network	Non-Network	
Lifetime Maximum	Unlimited		Unlimited		
Deductible (Single/Family)	\$300 / \$900	\$600 / \$1,800	\$300 / \$900	\$600 / \$1,800	Charges applied to the Network deductible will not apply towards the Non-network deductible and vice versa.
Out-of-pocket Maximums (Single/Family)	\$1,000 / \$2,000	\$2,000 / \$4,000	\$1,300 / \$2,900	\$2,600 / \$5,800	The deductible is included in out-of-pocket maximum. This was tracked as coinsurance maximums without the deductible. Network and non-network maximums do not cross apply.
Cost Share	10%	30%	10%	30%	
Physician Home and Office Services (includes PCP and SCP)					Office surgery is now covered under the office-visit copay. It was deductible and coinsurance.
Office visit	\$25 PCP / \$25 SCP	Deductible / 30%	\$25 PCP / \$25 SCP	Deductible / 30%	There is a \$5 allergy injection copayment per visit in the network office setting only if billed without an office visit charge. If there is an office-visit charge with the injection charge, the member pays the office-visit copay and not the allergy injection copay. If allergy serum is the only charge as a result of a network office visit, the member pays deductible / cost share instead of a copay.
Office Surgery	Deductible / 10%	Deductible / 30%	\$25	Deductible / 30%	
Allergy serum	Deductible / 10%	Deductible / 30%	Deductible / 10%	Deductible / 30%	
Allergy injections	Covered in full	Deductible / 30%	\$5	Deductible / 30%	
Allergy testing	\$25	Deductible / 30%	Deductible / 10%	Deductible / 30%	
Routine and non-routine mammograms	Covered in full	Deductible / 30%	\$25 regardless of setting	Deductible / 30%	MRAs, MRIs, CT-scans, PETS, nuclear cardiology imaging studies, stress tests, and non-routine maternity ultrasounds now are subject to the Other Outpatient Services cost share regardless of where services are received.
Diabetic education	\$25	Deductible / 30%	\$25	Deductible / 30%	Other Outpatient Services cost share will apply to all DME, DME vendor medical supplies, and prosthetic devices/appliances obtained in the office visit, urgent care, other outpatient setting, or home care setting.
MRAs, MRIs, PETS, CT-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds	Covered in full after copay	Deductible / 30%	Deductible / 10%	Deductible / 30%	

The information included here is simply an overview of key benefit changes in our standard product lines. It is not an exhaustive list of changes and is not a legal document. For complete details on all benefits, limitations and exclusions, please refer to the benefit contract. In the event of a conflict between this document and the contract, the contract will control.

Benefit	Blue Cross Current		Anthem New		Change
<p>Preventive Care Services Services include but are not limited to: routine exams, pelvic exams, Pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing exams</p> <p>Physician home and office visits</p> <p>Other outpatient services at hospital/alternative care facility</p> <p>Immunizations through age 5</p>	<p>\$25</p> <p>Deductible/ 10%</p> <p>Covered in full</p>	<p>Deductible/ 30%</p> <p>Deductible/ 30%</p> <p>Covered in full</p>	<p>\$25</p> <p>Deductible/ 10%</p> <p>Covered in full</p>	<p>Deductible/ 30%</p> <p>Deductible/ 30%</p> <p>Covered in full</p>	<p>Routine eye exam now is covered.</p> <p>There is no calendar-year benefit maximum. There was a \$150 calendar-year maximum for well adult.</p>
<p>Emergency and Urgent Care</p> <p>Emergency room services at hospital (facility/other covered services) copayment waived if admitted</p> <p>Urgent care center services</p> <p>Emergency ambulance services</p>	<p>Deductible/ 10%</p> <p>Deductible/ 10%</p> <p>Deductible/10%</p>	<p>Deductible/ 30% Balance billing applies</p> <p>Deductible/ 30%</p> <p>Network Deductible/ 10%</p>	<p>Deductible/ 10%</p> <p>10%</p> <p>Deductible/10%</p>	<p>Deductible/ 10% Balance billing applies</p> <p>Deductible/ 10%</p> <p>Network Deductible/ 10%</p>	<p>ER charges are paid at copay and now include separately billed doctor charges. There now is an urgent care center copay</p>
<p>Inpatient and Outpatient Professional Services Included but are not limited to:</p> <p>Medical care visits (1 per day) intensive medical care, concurrent care, consultation, surgery, administration of general anesthesia and newborn exams</p>	<p>Deductible/ 10%</p>	<p>Deductible/ 30%</p>	<p>Deductible/ 10%</p>	<p>Deductible/ 30%</p>	

Benefit	Blue Cross Current		Anthem New		Change
<p>Inpatient Facility Services Unlimited days except for:</p> <p>60 days Network/Non-network combined for physical medicine/rehab (limit includes day rehabilitation therapy services on an outpatient basis)</p> <p>90 days Network/Non-network combined for skilled nursing facility</p>	Deductible/ 10%	Deductible/ 30%	Deductible/ 10%	Deductible/ 30%	<p>Now there is a 60-day limit per benefit period for inpatient physical medicine/rehab. Previously we did not track inpatient physical medicine/rehab.</p> <p>Skilled Nursing now has a 90-day limit per benefit period. The limit was 100 day.</p>
<p>Outpatient Surgery (Hospital/Alternative Care Facility)</p>	Deductible/ 10%	Deductible/ 30%	Deductible/ 10%	Deductible/ 30%	
<p>Other Outpatient Services (including but not limited to):</p> <p>Non-surgical outpatient services such as MRIs, CT-scans, chemotherapy, ultrasounds, and other diagnostic outpatient services</p> <p>Home health care services (Network and Non-network combined) 90 visits per benefit series (excludes IV therapy)</p> <p>Durable medical equipment, orthotics (Network and Non-network combined \$4,000 benefit period maximum)</p> <p>Prosthetics (network and Non-network combined \$4,000 benefit period maximum.)</p> <p>Physical medicine therapy day rehabilitation programs</p> <p>Hospice care</p> <p>Non-emergency ambulance services</p>	Deductible/ 10%	Deductible/ 30%	Deductible/ 10%	Deductible/ 30%	<p>Breast prosthesis is covered whether internal or external following a mastectomy and four surgical bras per benefit period. Breast prosthesis is not subject to the maximum for prosthetic devices.</p> <p>Foot orthotics now are covered under the plan.</p> <p>HHC now is limited to 90 visits per benefit period. It was limited to 100 visits.</p> <p>Private duty nursing is covered under home care and has a separate limit of \$50,000 per benefit period and \$100,000 per lifetime. The dollar limits are combined Network and Non-network.</p> <p>When provided in the home, physical/manipulation therapy (excluding chiropractic services), occupational therapy, and speech therapy will accumulate towards the home care services limit only.</p> <p>DME & orthotics now have a benefit period maximum.</p> <p>Prosthetics now have a benefit period maximum.</p>

Benefit	Blue Cross Current		Anthem New		Change
<p>Outpatient Therapy Services (Combined Network and Non-network limits apply)</p> <p>Physician home and office visits (PCP/SCP)</p> <p>Other outpatient services at hospital/ alternative care facility</p> <p>Limits apply to:</p> <p>Physical/manipulation therapy excluding chiropractic services: 20 visits</p> <p>Occupational therapy: 20 visits</p> <p>Chiropractic services: 26 visits network only</p> <p>Speech therapy unlimited</p>	<p>\$25 and Deductible/ 10% for therapy</p> <p>Deductible/ 10%</p>	<p>Deductible/ 30%</p> <p>Deductible/ 30%</p>	<p>\$25</p> <p>Deductible/ 10%</p>	<p>Deductible/ 30%</p> <p>Deductible/ 30%</p>	<p>Speech therapy visits now are unlimited.</p> <p>All occupational therapy, physical therapy and speech therapy in the office is covered under the office-visit copay. It was covered under deductible/coinsurance after the member paid the copay for the office-visit charge.</p>
<p>Behavioral Health Services (Network & Non-network) Mental Health</p> <p>Inpatient facility services</p> <p>Physician home and office visits</p> <p>Other outpatient services (hospital/ alternative care facility)</p> <p>Substance Abuse</p> <p>Inpatient 21 days/6 detox</p> <p>Outpatient facility: 30 days</p> <p>Outpatient office visits: 30 visits</p> <p>(Substance abuse rehab programs are limited to 10 episodes per lifetime Network and Non-network combined.)</p>	<p>Deductible/ 10%</p> <p>\$25</p> <p>Deductible/ 10%</p> <p>Deductible/ 10%</p> <p>Deductible/ 10%</p> <p>\$25</p>	<p>Deductible/ 30%</p> <p>Deductible/ 30%</p> <p>Deductible/ 30%</p> <p>Deductible/ 30%</p> <p>Deductible/ 30%</p> <p>Deductible/ 30%</p>	<p>Deductible/ 10%</p> <p>\$25</p> <p>Deductible/ 10%</p> <p>Deductible/ 10%</p> <p>\$25</p>	<p>Deductible/ 30%</p> <p>Deductible/ 30%</p> <p>Deductible/ 30%</p> <p>Deductible/ 30%</p> <p>Deductible/ 30%</p> <p>Deductible/ 30%</p>	<p>There now is no limit to Non-network services for substance abuse rehabilitation programs. There was a \$5,000 lifetime maximum for Non-network services for substance abuse.</p>

Benefit	Blue Cross Current		Anthem New		Change
<p>Human Organ and Tissue Transplants Acquisition and transplant procedures, harvest and storage</p>	<p>Deductible/ 10% A set list of transplant procedures (including cornea and kidney) and covered services are subject to the same cost shares as other surgeries.</p>	<p>Deductible/ 30% A set list of transplant procedures (including cornea and kidney) and covered services are subject to the same cost shares as other surgeries.</p>	<p>Covered in full</p>	<p>Deductible/ 30%</p>	<p>Cornea and kidney transplants are covered the same as any other medical condition; other transplants are included under the HOTT benefits. No cost share for HOTT services received from a Network transplant provider. Non-network/non-participating (not participating in the transplant Network): the HOTT admission is subject to 30% cost share and does not accumulate to the Non-network/non-participating OPL. HOTT benefits do not apply to a covered service (related to a covered transplant procedure) received prior to or after the transplant benefit period. Transplant benefit period is defined as the period starting one day prior to the transplant and covered by the case rate/global fee arrangement for Network transplants, or continuing until the discharge date for Non-network transplants. HOTT services apply to the medical lifetime maximum. Eliminated EPO for ABMT — now treated same as other HOTT</p>
<p>Prescription Drugs</p> <p>Network Retail Pharmacy 30-day supply (includes diabetic test strip)</p> <p>Precision Rx Mail-Order Services (90-day supply (includes diabetic test strip)</p>	<p>Tier 1, 2 and 3: \$10/\$25/\$40 Tier 4: 20% up to a \$100 coinsurance maximum per prescription, with a \$2,000 coinsurance maximum per calendar year</p> <p>Tier 1, 2 and 3: \$20/\$50/\$80 Tier 4: 20% up to a \$200 coinsurance maximum per prescription, with a \$2,000 calendar maximum</p>	<p>Tier 1, 2 and 3: is appropriate tier copay plus 30% of allowed amount plus difference between the retail charge and allowed amount Tier 4 is 30% of allowed amount plus difference between the retail charge and allowed amount</p> <p>Not available</p>	<p>Tier 1, 2 and 3: \$10/\$25/\$40 Tier 4: 20% up to a \$100 coinsurance maximum per prescription, with a \$2,000 coinsurance maximum per calendar year</p> <p>Tier 1, 2 and 3: \$20/\$50/\$80 Tier 4: 20% up to a \$200 coinsurance maximum per prescription, with a \$2,000 coinsurance maximum per calendar year</p>	<p>Tier 1, 2 and 3: 50% cost share with a minimum \$45 per prescription Tier 4: 50% cost share with a minimum \$45 per prescription</p> <p>Not available</p>	<p>Diabetic test strips are copay Non-network pharmacy charges are paid at 50% with a minimum dollar amount. The mail order vendor will continue to be Precision Rx.</p>

Administrative Changes	Blue Cross Current	Anthem Change	Change
Network Name Changes	Alliance Choice and Alliance	Blue Access Choice and Blue Access PPO	A simple name change.
Pharmacy Vendors	Wellpoint Pharmacy Management for Retail and Precision Rx for Mail Order	WellNextRx for Retail and Precision Rx for Mail Order	A simple name change.
Laboratory Services	For Alliance and Alliance Choice, the member cost share is based on setting and if services are received from an independent lab in the network, no copayment is required.	No additional cost share for plans with office visit copayment designs if performed during a Network office visit or at a Network laboratory. For lab services at any other place of service, the applicable Network or Non-network cost shares apply according to the place of service where rendered.	
E-bill functionality	Have the ability to pull up Excel-document report with current employees enrolled on plan.	Will not have this functionality for several months.	
Dependent Child Ages	25/25 end of calendar year	A dependent is eligible until the end of the year in which he/she turns age 19 or to the end of the year in which the dependent turns age 24 if he/she qualifies as a full-time student in an accredited college, university, trade or secondary school on a full-time basis.	25/25 end of calendar year
Pre-existing (PPO products only)	Currently have a six month look back & an 18 month wait after enrollment for coverage of pre-existing to late enrollees.	New Hires, Special and Late Enrollees: 12-month pre-ex wait with a 6-month look back. Late enrollees must wait until open enrollment to come on the plan.	Can customize
Precertification	Currently have a penalty for non-participating providers of 20% that is the member's responsibility.	While precertification is required; there is no penalty to a member when precertification is not obtained.	
Maternity Coverage	Cover employee or spouse	Cover employee or spouse and dependent daughters	Cover employee or spouse