Britonkill CSD
Blue Shield CDPHP Benefit Comparison
March 29th, 2021

	Blue Shield PPO 816	CDPHP EPO $15	CDPHP EPO $20
DEDUCTIBLES/MAXIMUMS			.
In network deductible	N/A	N/A	N/A
In network coinsurance	N/A	N/A	N/A
In network out of pocket maximum	$6,600/$13,200*	$8150/$16,300	$8150/$16,300
Out of network deductible	$250/$500	N/A	N/A
Out of network coinsurance	20%	N/A	N/A
Out of network out of pocket maximum	$2,500/$5,000	N/A	N/A
Out of network annual maximum	Unlimited	N/A	N/A
Out of network lifetime maximum	Unlimited	N/A	N/A
Annual maximum	Unlimited	Unlimited	Unlimited
Benefit administration	Calendar year benefits	Plan Year Benefits	Plan Year Benefits
Dependent age	26	26	26
Student age	26	26	26
Dependent/Student coverage ends	End of birth month	End of birth month	End of birth month
PHYSICIAN SERVICES – Office			
Primary care physician copay	$20	$15	$20
Specialist copay	$20	$15	$20
Pediatric visits for children up to age 19	$20	$15	$20
Well child visits and immunizations for children up to age 19	Covered in full	Covered in Full	Covered in Full
Allergy immunotherapy	Covered in full	Covered in Full	Covered in Full
Chiropractic	$20	$15	$20
Laboratory services	Covered in full	Covered in full	Covered in full
Radiology (x-ray, MRI, CT & other high tech imaging)	Covered in full	Covered in full	Covered in full
Pre & post natal care	Covered in full after initial $20 copay	Covered in Full	Covered in Full
PHYSICIAN SERVICES - Routine/Preventive			
Abdominal aortic aneurysm screening	Covered in full	Covered in Full	Covered in Full
Adult immunizations	Covered in full	Covered in Full	Covered in Full
Flu shot	Covered in full	Covered in Full	Covered in Full
Bone mineral density	Covered in full	Covered in Full	Covered in Full
Colorectal cancer screening	Covered in full	Covered in Full	Covered in Full
Colonoscopy	Covered in full	Covered in Full	Covered in Full
Routine mammogram	Covered in full	Covered in Full	Covered in Full
OB/GYN	Covered in full	Covered in Full	Covered in Full
Routine pap smear	Covered in full	Covered in Full	Covered in Full
Physical exam	Covered in full	Covered in Full	Covered in Full
PSA test	Covered in full	Covered in Full	Covered in Full
Routine eye exam	Covered in full every other year	$15 every 24 months	$20 every 24 months
HOSPITAL			
Inpatient hospital stay	Covered in full	Covered in full	Covered in full
Inpatient maternity stay	Covered in full	Covered in full	Covered in full
Inpatient physical rehab (60 days)	Covered in full	Covered in full	Covered in full

Outpatient surgery	**Covered in full**	**$15**	**$20**
EMERGENCY HOSPITAL CARE			
Emergency room (copay waived if admitted to hospital)	**$35**	**$50**	**$50**
Ambulance - ground ambulance	**$50**	**$50**	**$50**
Ambulance - air ambulance	**$50**	**$50**	**$50**
Urgent care centers	**$20**	**$25**	**$30**
MENTAL HEALTH & SUBSTANCE ABUSE			
Mental health (inpatient)	**Covered in full**	**Covered in Full**	**Covered in Full**
Mental health (outpatient)	**Covered in full**	**$15**	**$20**
Alcohol & substance abuse (inpatient detox)	**Covered in full**	**Covered in Full**	**Covered in Full**
Alcohol & substance abuse (inpatient rehab)	**Covered in full**	**Covered in Full**	**Covered in Full**
Alcohol & substance abuse (outpatient) Covered in full	**Covered in full**	**$15**	**$20**
OTHER SERVICES			
Cardiac rehabilitation (24 visits)	**$20**	**Covered in full**	**Covered in full**
Chemotherapy	**$20**	**$15**	**$20**
Dialysis	**$20**	**$15**	**$20**
Durable medical equipment	**Covered in full in network**	**20% coinsurance**	**20% coinsurance**
Home care (100 visits)	**$20**	**Covered in full**	**Covered in full**
Hospice (210 days)	**Covered in full**	**Covered in full Inpatient, $15 outpatient**	**Covered in full Inpatient, $20 outpatient**
Physical, speech & occupational therapy (60 visits aggregate)	**$20**	**$15**	**$20**
Prosthetic and orthotic appliances	**Covered in full in network**	**20% coinsurance**	**20% coinsurance**
Radiation therapy	**$20**	**$15**	**$20**
Skilled nursing facility (120 days)	**$250**	**Covered in full (90 days)**	**Covered in full (90 days)**
Rx			
Retail	**$10 generic drugs, $25 for brand drugs, $25 for non-formulary and specialty**	**$5 generic drugs, $25 for brand drugs, $40 for non-formulary and specialty**	**$5 generic drugs, $25 for brand drugs, $40 for non-formulary and specialty**
Mail Order	**2 co-pays for a 90 day supply**	**2.5 co-pays for a 90 day supply**	**2.5 co-pays for a 90 day supply**
Rx Out of Pocket Maximum	**$2100/$4200**	**Included in medical OOP**	**Included in medical OOP**
Monthly Premium	**Single: $760.89** **2Person: $1,515.80** **Family: $2,156.32** **Medicare: $506.13**	**Single: $840.13** **2Person: $1,757.26** **Family: $2,330.91**	**Single: $845.67** **2Person: $1,688.35** **Family: $2,211.48**
	****Single: $764.61** ****2Person: $1,523.23** ****Family: $2,166.91** ****Medicare: $513.16**		

*Does not include out of pocket costs associated with Rx

** Rate with 90 day drug supply at retail