

# H E A L T H P L A N C O M P A R I S O N



## BUILDING TRADES EMPLOYEES INSURANCE FUND (BTEIF) Excellus BlueCross BlueShield CNY & Utica Region Healthy Blue

PLAN FEATURES	In-Network	Out-of-Network
Primary Care Physician (PCP)		Notrequired
Referrals		Notrequired
Out of network benefits	N/S	Covered at 80%, subject to the deductible
Out of area benefits	Coverage provided worldwide through the BlueCard® program.	
Student/Dependent coverage	Qualified students and dependents covered to age 26.	
Wellness Program	Healthy Rewards	
<b>Plan Cost Sharing Highlights</b>		
Office visit copay (PCP)	Adults: \$15 per visit • Children to age 19: \$0 per visit	Covered at 80%, subject to the deductible
Office visit copay (Specialist)	Adults & Children: \$25 per visit	Covered at 80%, subject to the deductible
Coinsurance	0%	20%
Deductible	None	\$500/\$1,500
Out of pocket maximum	None	\$1,500/\$4,500
Lifetime Maximum	None	None
<b>Plan Benefits</b>		
<b>Preventative Healthcare Services</b>		
Well child visits	Covered in full	Covered in full
Adult routine physical exams	Covered in full for up to one exam per calendar year	Covered at 80%, subject to the deductible for up to one exam per calendar year
Adult immunizations	Covered in full	Covered at 80%, subject to the deductible
Mammography	Covered in full	Covered at 80%, subject to the deductible
Pap smear	Covered in full	Covered at 80%, subject to the deductible
Routine GYN Exam	Covered in full	Covered at 80%, subject to the deductible
Prostate cancer screening	Covered in full	Covered at 80%, subject to the deductible
Routine vision	\$25 copay per visit for up to 1 visit per calendar year \$60 eyewear allowance per member each calendar year.	Covered at 80%, subject to the deductible for up to 1 visit per calendar year \$60 eyewear allowance per member each calendar year.
<b>Physicians Office Services</b>		
Diagnostic office visits	PCP: Adults \$15 copay per visit • PCP: Children to age 19 \$0 copay per visit Specialist: Adult & Children \$25 copay per visit	Covered at 80%, subject to the deductible
Diagnostic x-rays (MRI,PET,CAT scans)	\$25 copay per visit	Covered at 80%, subject to the deductible
Diagnostic lab. & pathology	Covered in full	Covered at 80%, subject to the deductible
Allergy Tests	PCP: Adults \$15 copay per visit • PCP: Children to age 19 \$0 copay per visit Specialist: Adult & Children \$25 copay per visit	Covered at 80%, subject to the deductible
Allergy Injections	PCP: Adults \$15 copay per visit • PCP: Children to age 19 \$0 copay per visit Specialist: Adult & Children \$25 copay per visit	Covered at 80%, subject to the deductible
Chemotherapy	\$15 copay for IV/injectable chemotherapy, in addition to a \$15 copay for the office visit	Covered at 80%, subject to the deductible
Radiation Therapy	\$25 copay per visit	Covered at 80%, subject to the deductible
<b>Maternity Services</b>		
Prenatal and postpartum care	Covered in full	Covered at 80%, subject to the deductible
Hospital care for mom (inc. delivery)	\$500 copay per admission	Covered at 80%, subject to the deductible
Newborn nursery care	Covered in full	Covered at 80%, subject to the deductible
<b>Prescription Drug</b>		
<small>Short-term and maintenance drugs are covered under the following copayments for each 30 day supply per prescription at participating retail pharmacies, up to a 90-day supply for two copays is available through Express Scripts, Inc. mail order service. Contraceptives inc.</small>	\$5/\$25/\$50 with \$0 generics for kids to age 19 and \$1,000 maximum per member per calendar year for brand-name drugs	Not covered
<b>Inpatient Hospital Benefits</b>		
Hospital Benefits	\$500 copay per admission for unlimited days	Covered at 80%, subject to the deductible
Physician visits in the hospital	Covered in full	Covered at 80%, subject to the deductible
Inpatient Physical Rehabilitation	\$500 copay per admission for up to 60 days per calendar year	Covered at 80%, subject to the deductible for 60 days per calendar year
Surgery	\$500 copay per admission for unlimited days	Covered at 80%, subject to the deductible
Anesthesia	Covered in full	Covered in full
<b>Emergency Care</b>		
Emergency room care	\$250 copay. Waived if admitted as inpatient	\$250 copay. Waived if admitted as inpatient
Freestanding urgent care center	\$25 copay per emergency	Covered at 80%, subject to the deductible
Ambulance	\$250 copay per emergency	\$250 copay per emergency
<b>Outpatient Hospital Benefits</b>		
Diagnostic x-rays (MRI,PET,CAT scans)	\$25 copay per visit	Covered at 80%, subject to the deductible
Diagnostic lab. & pathology	Covered in full	Covered at 80%, subject to the deductible
Surgical Care	\$250 copay	Covered at 80%, subject to the deductible
Chemotherapy	\$15 copay for IV/injectable chemotherapy, in addition to a \$15 copay for the office visit	Covered at 80%, subject to the deductible
Radiation Therapy	\$25 copay per visit	Covered at 80%, subject to the deductible
<b>Mental Health &amp; Chemical Dependence Benefits</b>		
Inpatient mental health care	\$500 copay per admission for up to 30 days per calendar year	Covered at 80%, subject to the deductible for up to 30 days per calendar year
Outpatient mental health care	\$25 copay per visit for up to 20 visits per calendar year	Covered at 80%, subject to the deductible for up to 30 days per calendar year
Inpatient chemical dependence care	\$500 copay per admission for up to 7 days detoxification and 30 days of rehabilitation per calendar year, limited to 2 admissions per lifetime.	Covered at 80%, subject to the deductible for up to 7 days per calendar year for detoxification and 30 days per calendar year for rehabilitation, limited to 2 admissions per lifetime.
Outpatient chemical dependence care	\$25 copay per visit for up to 60 visits per calendar year	Covered at 80%, subject to the deductible for up to 60 visits per calendar year
<b>Other Services</b>		
Diabetic insulin & supplies	\$15 copay for each 30 day supply	Covered at 80%, subject to the deductible for each 30 day supply
Skilled nursing facility	\$500 copay per admission for up to 45 days per calendar year	Covered at 80%, subject to the deductible for up to 45 days per calendar year
Home care	Covered in full for up to 40 visits per calendar year	Covered at 80%, subject to \$50 deductible for up to 40 visits per calendar year
Hospice	Covered in full for unlimited visits	Covered at 80%, subject to the deductible for unlimited visits
Outpatient therapy	\$25 copay per visit for up to 45 visits for physical, speech, and occupational therapy combined	Covered at 80%, subject to the deductible for up to 45 visits for physical, speech, and occupational therapy combined
Durable medical equipment (DME)	Covered at 80% for up to \$15,000 per member per calendar year combined with DME and orthotics	Covered at 80%, subject to deductible for up to \$15,000 per member per calendar year combined with DME and orthotics
External prosthetics	Covered at 80% for up to \$15,000 per member per calendar year combined with DME and orthotics	Covered at 80%, subject to deductible for up to \$15,000 per member per calendar year combined with DME and orthotics
Chiropractic	\$25 copay per visit	Covered at 80%, subject to the deductible
Acupuncture	\$25 copay per visit for up to 10 visits per calendar year	Covered at 80%, subject to the deductible for up to 10 visits per calendar year
Dental	\$25 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
Hearing	Routine hearing exams with \$25 copay for up to 1 exam per calendar year. Hearing aids covered up to \$600 allowance every 3 years for children to age 19	Covered at 80%, subject to the deductible for up to 1 exam per calendar year. Hearing aids covered up to \$600 allowance every 3 years for children to age 19

This is not a contract of binding agreement; it is a summary of benefits and services. For complete details, please refer to your member contract. Note: all limits are combined In Network and Out of Network