

# Benefit Comparison Chart for Dartmouth College Employees



Covered Services	BlueChoice <sup>®†</sup> (POS)		
	In-Network		Out-of-Network
	What you pay when your PCP provides/arranges your care	What you pay when you receive care from a BlueChoice Specialist without a referral from your PCP	
<b>Physician Services</b> Office visit, specialist visit, physical exam, well child office visit (2 years and older) Well baby office visit (under 2 years old)	\$10 copay per visit	\$25 copay per visit	\$300 deductible No more than \$900 per family each year  20% coinsurance No more than \$1,200 per member each year  Some self referred benefits are subject to precertification requirements. Refer to your Subscriber Certificate for details.  Individual out-of-pocket \$1,500 Family out-of-pocket, per year \$4,500
Routine Gyn Visit**	You pay \$0	You pay \$10	
Childhood immunizations	You pay \$0	\$150 deductible No more than \$450 per family each year  20% coinsurance No more than \$900 per member each year  Individual out-of-pocket \$1,050 Family out-of-pocket, \$3,150 per year	
Other physician services, surgical services, inpatient medical care, diagnostic testing, lab, x-ray, maternity care	You pay \$0		
<b>Outpatient Services</b>	You pay \$0		
<b>Inpatient Hospital Services</b>	You pay \$0		
<b>Skilled Nursing Facility and Rehabilitation</b> (100 days per member per calendar year)	You pay \$0		
<b>Hospice Services</b>	You pay \$0		
<b>Home Health Services</b> Subject to medical necessity	You pay \$0		
<b>Physical and Occupational Therapy</b> (Combined \$5,000 per member per calendar year)	You pay \$0		
<b>Speech Therapy</b> (\$5,000 per member per calendar year)	You pay \$0		
<b>Emergency Room</b>	You pay \$50 (\$0 if admitted)		
<b>Ambulance</b> (subject to medical necessity)	You pay \$0	You pay \$0	
<b>Chiropractic Services**</b> (Maximum of 20 visits per year)	N/A	You pay \$10	
<b>Inpatient Mental Health &amp; Substance Abuse Services*</b>	You pay \$0 when arranged through Anthem Behavioral Health	N/A	Subject to deductible and coinsurance
<b>Outpatient Mental Health &amp; Substance Abuse Services*</b>	You pay \$10 when arranged through Anthem Behavioral Health		Subject to deductible and coinsurance
<b>Prescription Drug</b>	<b>Mail order benefits available for 90 day supply at co-payment listed below</b>		
	30 Day Supply Co-payment \$5 Generic \$15 Formulary Brand \$30 Non-Formulary Brand		
<b>Vision Care**</b>	Annual exam for adults and children. \$40 reimbursement toward eyewear.		
<b>Maximum Lifetime Benefit</b>	Unlimited		
<b>Fitness Reimbursement</b>	Up to \$200 per family, per year		

\* Care is arranged through Anthem Behavioral Health Network by calling 1-800-228-5975

\*\* No Primary Care Physician referral needed.

This chart is intended for summary purposes only. Please refer to your Subscriber Certificate for details.

<b>Covered Services</b>	<b>Preferred Blue® (PPO)</b>		<b>Indemnity</b>
	<b>Network</b>	<b>Out-of-Network</b>	<b>\$1,500 Deductible</b>
<b>Physician Services</b> Office visit, specialist visit, physical exam, routine GYN visit, well child office visit (2 years and older) Well baby office visit (under 2 years old)	\$15 copay per visit		<b>You Pay:</b>  Deductible \$1,500 individual \$3,000 family  100% coverage after deductible  Annual out-of-pocket maximum \$1,500 Individual, \$3,000 family
Childhood immunizations	You pay \$0		
<b>Medical Services</b> Medical exam, injections (including allergy injections) Lab, X-ray and ultrasound	\$15 per visit  Covered in full	\$500 deductible No more than \$1,500 per family each year	
<b>Outpatient Services</b> Physician and professional services, surgery, anesthesia, delivery of baby <b>Inpatient Hospital Services</b> Semi-private room and board Physician in-hospital care, maternity care, surgery, anesthesia, lab, X-ray, CT scan, MRI, medical supplies, medication and physical, occupational and speech therapy	Subject to: \$250 deductible per member, no more than \$750 per family per calendar year  Covered at 100% after the deductible is met	20% coinsurance No more than \$1,000 per member each year, no more than \$3,000 per family per calendar year  Some out-of-network benefits are subject to precertification requirements. Refer to your Subscriber Certificate for details	
<b>Skilled Nursing Facility and Physical Rehabilitation Facility</b> (100 days per member per calendar year for each**)	You pay \$0	Annual out-of-pocket, maximum \$1,500 per individual \$4,500 per family	
<b>Hospice Services</b>	You pay \$0		
<b>Home Health Services</b> Subject to medical necessity	You pay \$50		
<b>Physical, Occupational and Speech Therapy</b> (Combined \$5,000 per member per calendar year**)	\$15 copay per visit		
<b>Emergency Room</b>	You pay \$75 (You pay \$0 if admitted)		
<b>Ambulance</b> (subject to medical necessity)	Deductible/Coinsurance	Same as network	
<b>Chiropractic Services</b> (Maximum of 20 visits per year**)	You pay \$15	Subject to deductible and coinsurance	
<b>Inpatient Mental Health &amp; Substance Abuse Services*</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and then 20% coinsurance after deductible is met
<b>Outpatient Mental Health &amp; Substance Abuse Services*</b>	You pay \$15 when arranged through Anthem Behavioral Health	Subject to deductible and coinsurance	
<b>Prescription Drug</b>	<b>Mail order benefits available for 90 day supply at co-payment listed below</b>  30 Day Supply Co-payment \$5 Generic \$15 Formulary Brand \$30 Non-Formulary Brand		Subject to deductible Must pay up front for prescription drugs at pharmacy and request reimbursement from Anthem
<b>Vision Care</b>	\$15 copay	\$15 copay	N/A
<b>Maximum Lifetime Benefit</b>	unlimited		
<b>Fitness Reimbursement</b>	up to \$200 per family per year		

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\*\* PPO Only

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