Health Plans Comparison Sheet

Effective 10/1/2017 – 9/30/2018

The chart below highlights key features and benefits under the City of Montgomery Blue Cross Blue Shield Health Plans: Traditional PPO Plan and HMP High Deductible Plan. See the Summary of Benefits and Coverage on montgomeryal.gov for more details.

Benefit	Traditional PPO Plan		HMP High Deductible Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible	Individual - $300 Family - $900 max		Individual - $1500 Family - $3000	Individual - $3000 Family - $6000
Out-of-Pocket Maximum	Individual - $2500 Family - $5000		Individual - $4000 Family - $8000	No out-of-pocket maximum for out-of-network services
	All deductibles, copays, and coinsurance for in-network services apply to the out-of-pocket maximum. Out-of-network services do not apply to the out-of-pocket maximum. After you reach Calendar Year Out-of-Pocket Maximum, applicable expenses are covered at 100% for remainder of calendar year.		Calendar year deductible amounts met in-network will not apply to the out-of-network calendar year deductible. Calendar year deductible amounts met out-of-network will not apply to the in-network calendar year deductible. After you reach the Calendar Year Out-of-Pocket Maximum, applicable expenses are covered at 100% for remainder of calendar year.	
INPATIENT HOSPITAL FACILITY SERVICES **Preadmission Certification is required for all inpatient admissions (except emergency hospital admissions and maternity); notification within 48 hours for emergencies. Call 1-800-248-2342 for precertification.**				
Inpatient Hospital	$300 per admission deductible. $60 copay per day for days 2-5	$500 per admission deductible.	100% after deductible	Covered at 60% after deductible
OUTPATIENT HOSPITAL SERVICES				
Outpatient Surgery (Including Ambulatory Surgical Centers)	100% of the allowance, subject to a $175 facility copay	65% of the allowance, after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Emergency Room (Medical Emergency)	100% of the allowance, subject to a $150 facility copay	100% of the allowance, subject to a $150 facility copay and the calendar year deductible	Covered at 80% after deductible	Covered at 80% after deductible
Emergency Room (Accidental Injury)	100% of the allowance with no deductible or copay required	100% of the allowance with no deductible or copay for services rendered within 72 hours; thereafter 65% of the allowance, after deductible	Covered at 80% after deductible	Covered at 80% after deductible for services rendered within 72 hours; thereafter 60% after deductible
Emergency Room Physician Fees	100% of the allowance subject to a $60 copay	100% of the allowance subject to a $60 copay and the calendar year deductible	Covered at 80% subject to calendar year	Covered at 80% subject to calendar year
Outpatient Diagnostic Lab, X-Ray, Pathology, Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	100% of the allowance with no deductible or copay	65% of the allowance, after deductible	Covered at 80% after deductible	Covered at 60% after deductible
PHYSICIAN BENEFITS				
Office Visits & Consultations	100% of the allowance subject to a $50 copay for Primary Physician; $60 copay for Specialist	65% of the allowance, after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Surgery & Anesthesia	100% of the allowance with no deductible or copay	65% of the allowance, after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Second Surgical Opinions	100% of the allowance with no deductible or copay	65% of the allowance, after deductible	Covered at 80% after deductible	Covered at 60% after deductible
Maternity	100% of the allowance with no deductible or copay	65% of the allowance, after deductible	Covered at 80% after deductible	Covered at 60% after deductible

PREVENTIVE CARE SERVICES Visit www.bcbsal.org/preventiveservices for a listing of the specific immunizations and preventive services				
Benefit	**Traditional PPO Plan**		**HMP High Deductible Plan**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Routine Immunizations & Preventive Services	100% of the allowance with no deductible or copay.	Not Covered	100%; no deductible	Not Covered
Additional Routine Preventive Services	100% of the allowance with no deductible or copay. • Urinalysis (when necessary) • CBS (when necessary) • TB skin test (when necessary) • Bone density test (one per calendar year for female employees and dependents age 50 and older)	Not Covered	100% of the allowance; no deductible. • Urinalysis (when necessary) • CBS (when necessary) • TB skin test (when necessary) • Bone density test (one per calendar year for female employees and dependents age 50 and older)	Not Covered
BENEFITS FOR OTHER COVERED SERVICES				
Allergy Testing & Treatment	Covered at 80% of the allowance, after deductible		Covered at 80% after deductible	Covered at 60% after deductible
Ambulance Service	Covered at 80% of the allowance, after deductible		Covered at 80% after deductible	Covered at 60% after deductible
Participating Chiropractic Services	Covered at 80% of the allowance, after deductible	Covered at 80% of the allowance, after deductible. Non-Participating in Alabama: 50% of the allowance, after deductible	Covered at 80% after deductible	Covered at 60% after deductible. Non-Participating in Alabama: 50% after deductible
Durable Medical Equipment (DME)	Covered at 80% of the allowance, after deductible		Covered at 80% after deductible	Covered at 60% after deductible
Physical Therapy	Covered at 80% of the allowance, after deductible		Covered at 80% after deductible	Covered at 60% after deductible
Occupational Therapy	Covered at 80% of the allowance, after deductible. Limited to certain services related to the hand and lymphedema.		Covered at 80% after deductible. Limited to certain services related to the hand and lymphedema.	Covered at 60% after deductible. Limited to certain services related to the hand and lymphedema.
HOME HEALTH AND HOSPICE SERVICES **Precertification required for services rendered outside of Alabama. Call 1-800-821-7231.**				
Preferred Home Health & Hospice	100% of the allowance with no deductible or copay.	65% of the allowance after deductible. Non-Preferred in Alabama: Not Covered	Covered at 80% after deductible	Covered at 60% after deductible. Non-Preferred in Alabama: Not Covered
HEALTH MANAGEMENT BENEFITS				
Individual Case Management	Coordinates care in the event of a catastrophic or lengthy illness or injury. For more information, call 1-800-821-7231.			
Disease Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.			
Baby Yourself	Prenatal wellness program. If a member enrolls before 24 weeks gestation, both inpatient per admission deductible and inpatient per day copay are waived when the member is admitted to the hospital for the delivery of the baby. For more information, call 1-800-222-4379 or visit www.behealthy.com.		Prenatal wellness program. If a member enrolls before 24 weeks gestation, $300 will be added to your Health Reimbursement Account to be used towards any allowed prenatal care services. For more information, please call 1-800-222-4379 or visit www.behealthy.com.	