



Blue EPO Balance benefits
Prepared for The Otsego County Chamber

12/2/2008

Type of Care/Plan Benefits	In-Network
<p>Plan features</p> <ul style="list-style-type: none"> • Primary Care Physician (PCP) • Referrals • Out of network benefits • Out of area benefits • Student/Dependent coverage • Domestic partner <p>Plan cost-sharing highlights</p> <ul style="list-style-type: none"> • Office visit copay (Primary Care Physician) • Office visit copay (Specialist) • Coinsurance • Deductible • Out of pocket maximum • Lifetime maximum 	<ul style="list-style-type: none"> • Not required • Not required • Not covered • Coverage provided worldwide through the BlueCard® program. • Qualified dependents are covered to age 19. Qualified students are covered to age 23. • Not covered • \$15 copay • \$15 copay • 15% • \$500 individual/\$1,500 family • \$1,500 individual/\$4,500 family • None
Type of Care/Plan Benefits	In-Network
<p>Preventive Health Care Services</p> <ul style="list-style-type: none"> • Well child visits • Adult routine physical exams • Adult immunizations • Mammography • Pap smear • Routine GYN exam • Prostate cancer screening • Routine vision <p>Physician Office Services</p> <ul style="list-style-type: none"> • Diagnostic office visits • Diagnostic x-rays • Diagnostic laboratory and pathology • Allergy tests • Allergy injections • Chemotherapy • Radiation therapy <p>Maternity Services</p> <ul style="list-style-type: none"> • Prenatal and postpartum care • Hospital care for mom (including delivery) • Newborn nursery care 	<ul style="list-style-type: none"> • Covered in full • \$15 copay per visit, limited to one exam per calendar year • Not covered • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • \$15 copay for one routine exam every 2 years • \$15 copay per visit • Covered at 85%, subject to the deductible. Precertification applies to MRI, PET and CAT scans. • \$15 copay per visit • \$15 copay per visit • \$15 copay per visit • Covered at 85%, subject to the deductible • Covered at 85%, subject to the deductible • \$15 copay per visit • Covered at 85%, subject to the deductible • Covered at 85%, subject to the deductible

continued

Type of Care/Plan Benefits	In-Network
<p>Prescription Drug</p> <ul style="list-style-type: none"> • Short-term and maintenance drugs <p>Inpatient Hospital Benefits</p> <ul style="list-style-type: none"> • Hospital benefits • Physician visits in the hospital • Inpatient physical rehabilitation • Surgery • Anesthesia <p>Emergency Care</p> <ul style="list-style-type: none"> • Emergency room care • Freestanding urgent care center • Ambulance <p>Outpatient Hospital Benefits</p> <ul style="list-style-type: none"> • Diagnostic x-rays • Diagnostic laboratory and pathology • Surgical care • Chemotherapy • Radiation therapy <p>Mental Health and Chemical Dependence</p> <ul style="list-style-type: none"> • Inpatient mental health care • Outpatient mental health care • Inpatient chemical dependence • Outpatient chemical dependence <p>Other Services</p> <ul style="list-style-type: none"> • Diabetic insulin and supplies • Skilled nursing facility • Home care • Outpatient therapy • Durable medical equipment • External prosthetics • Chiropractic • Acupuncture • Dental • Hearing 	<ul style="list-style-type: none"> • \$10/\$30/\$50; \$0 copay for generics for children to age 19 • Covered at 85%, subject to the deductible. Precertification applies. • Covered at 85%, subject to the deductible • Covered at 85%, subject to the deductible for up to 60 days per calendar year. Precertification applies. • Covered at 85%, subject to the deductible • Covered at 85%, subject to the deductible • \$50 copay per visit, unless admitted within 24 hours • \$25 copay per visit • \$50 copay • Covered at 85%, subject to the deductible. Precertification applies to MRI, PET and CAT scans • \$15 copay per visit • Covered at 85%, subject to the deductible • Covered at 85%, subject to the deductible • Covered at 85%, subject to the deductible • Covered at 85%, subject to the deductible for up to 30 days per calendar year. Precertification applies. • \$15 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider office. • Covered at 85%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per calendar year. Precertification applies. • Covered at 85%, subject to the deductible for up to 60 visits per calendar year • \$15 copay for up to a 30 day supply • Covered at 85%, subject to the deductible for up to 45 days per calendar year. Precertification applies. • Covered at 85%, subject to a \$50 deductible for unlimited visits per calendar year. Precertification applies. • Covered at 85%, subject to the deductible for a combined total of 40 visits per calendar year for physical, speech, occupational and respiratory therapy • Covered at 50% • Covered at 50%, up to \$15,000 per calendar year • \$15 copay per visit • Not covered • \$15 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly • Routine exams not covered

*Must be supplied by a participating provider.

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. 12/2/2008

This is not a contract or binding agreement; it is a summary of benefits and services. For complete details, please refer to your member contract. There may be additional coverage for biologically-based mental illness and for pg. 2