



HMOBlue 25 benefits
Prepared for The Otsego County Chamber

12/2/2008

Type of Care/Plan Benefits	Coverage
<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 • Lifetime maximum 	<ul style="list-style-type: none"> • Required • Required • Not covered • Emergency coverage provided worldwide through the BlueCard® program. • Qualified dependents are covered to age 19. Qualified students are covered to age 23. • Not covered • \$25 copay • \$40 copay • None • None • None
<p>Type of Care/Plan Benefits</p> <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 	<p>Coverage</p> <ul style="list-style-type: none"> • Covered in full • \$25 copay per visit • \$25 copay per visit • \$25 copay • \$25 copay • \$25 copay • \$25 copay • \$25 copay • \$40 copay for one routine exam every 2 years; every year for children to age 19. • \$25 copay per visit • \$40 copay per visit • \$25 copay per visit • \$25 copay per visit to your PCP; \$40 copay per visit to a specialist • \$25 copay per visit to your PCP; \$40 copay per visit to a specialist • \$25 copay per visit • \$25 copay per visit • \$5 copay per visit for first 10 visits, remainder of visits are covered in full • Facility: Subject to \$500 copay per admission; Physician: Subject to \$200 copay or 20% coinsurance, whichever is less • Covered in full

continued

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<p>Prescription Drug</p> <ul style="list-style-type: none"> • Short-term and maintenance drugs are covered up to a 30-day supply at participating retail pharmacies; 90-day supply (subject to two copays per 90-day supply) is available through PrimeMail® mail order pharmacy. Contraceptives included. 	<ul style="list-style-type: none"> • \$10/\$30/\$50
<p>Inpatient Hospital Benefits</p> <ul style="list-style-type: none"> • Hospital benefits • Physician visits in the hospital • Inpatient physical rehabilitation • Surgery • Anesthesia 	<ul style="list-style-type: none"> • Subject to \$500 copay per admission for unlimited days • Covered in full • Subject to \$500 copay per admission for 60 days per calendar year • Facility: Subject to \$500 copay; Physician: Subject to 20% coinsurance or \$200 copay, whichever is less • Covered in full
<p>Emergency Care</p> <ul style="list-style-type: none"> • Emergency room care • Freestanding urgent care center • Ambulance 	<ul style="list-style-type: none"> • \$100 copay per visit, unless admitted within 24 hours • \$35 copay per visit • \$100 copay
<p>Outpatient Hospital Benefits</p> <ul style="list-style-type: none"> • Diagnostic x-rays • Diagnostic laboratory and pathology • Surgical care • Chemotherapy • Radiation therapy 	<ul style="list-style-type: none"> • \$40 copay per visit • \$25 copay per visit • Facility: \$75 copay; Physician: Subject to 20% or \$200 copay, whichever is less • \$25 copay per visit • \$25 copay per visit
<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 	<ul style="list-style-type: none"> • Subject to \$500 copay per admission for up to 30 days per calendar year. Precertification applies. • \$40 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider office. • Subject to \$500 copay per admission for up to 7 days for detoxification only per calendar year. Precertification applies. • \$25 copay per visit for up to 60 visits per calendar year
<p>Other Services</p> <ul style="list-style-type: none"> • Diabetic insulin and supplies • Skilled nursing facility • Home care • Hospice • Outpatient therapy • Durable medical equipment 	<ul style="list-style-type: none"> • \$25 copay for up to a 30 day supply • Subject to \$500 copay per admission for up to 45 days per admission, 360 days per lifetime • Covered in full for up to 40 visits per calendar year • Subject to \$500 copay per admission for up to 210 days per lifetime • \$40 copay per visit for up to a combined total of 30 visits per calendar year for physical, speech, respiratory and occupational therapy • Covered at 50%



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<ul style="list-style-type: none">• External prosthetics• Chiropractic• Acupuncture• Dental• Hearing	<ul style="list-style-type: none">• Covered at 50%, up to \$15,000 per calendar year• \$40 copay per visit• Not covered• \$40 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly• Routine exams not covered. Hearing aids covered up to \$600 for up to 2 hearing aids every 3 years for children to age 19.

*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