



HealthyBlue benefits

Prepared for The Otsego Chamber of Commerce

3/10/2009

Type of Care/Plan Benefits	In-Network	Out Of 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 • Covered at 60%, subject to the deductible • Coverage provided worldwide through the BlueCard® program. • Qualified dependents are covered to age 19. Qualified students are covered to age 23. • Covered <ul style="list-style-type: none"> • Adult: \$15 Copay per visit; Children to age 19: \$0 Copay per visit • \$25 copay per visit • In-network: 20%; Out-of-network: 40% • Combined in and out of network: \$500 individual/\$1,500 family • Combined in and out of network: \$1,500 individual/\$4,500 family • None 	

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<p>HealthyRewards</p> <ul style="list-style-type: none"> • Earn cash back with HealthyRewards <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 • Colonoscopy 	<ul style="list-style-type: none"> • Earn up to \$1,000 in rewards per family by scheduling regular check-ups, eating right and staying active. Then get paid anytime throughout the year. • Covered in full • Covered in full for 1 exam per calendar year • Covered in full • Covered in full • Covered in full • Covered in full • Covered in full • \$25 copay for one routine exam every year; \$60 eyewear allowance available per calendar year • Preventive covered in full, diagnostic covered according to the surgical benefit 	<ul style="list-style-type: none"> • Covered in full • Covered at 60%, subject to the deductible for one routine exam per calendar year • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible for one routine exam per calendar year • Covered at 60%, subject to the deductible

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<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 	<ul style="list-style-type: none"> • Adult: \$15 copay per visit to your PCP; \$25 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$25 copay per visit to a specialist. • \$25 copay per visit • Covered in full • Adult: \$15 copay per visit to your PCP; \$25 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$25 copay per visit to a specialist. • Adult: \$15 copay per visit to your PCP; \$25 copay per visit to a specialist. Child: \$0 copay per visit to your PCP; \$25 copay per visit to a specialist. • \$15 copay per visit • \$25 copay per visit 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible
<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 at 80%, subject to the deductible • Covered at 80%, subject to the deductible • Covered in full 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible
<p>Prescription Drug</p> <ul style="list-style-type: none"> • Short-term and maintenance drugs 	<ul style="list-style-type: none"> • \$5/\$25/\$50; \$0 copay for generics for children to age 19. 	<ul style="list-style-type: none"> • Not covered
<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"> • Covered at 80%, subject to the deductible. • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible for up to 60 days per calendar year • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible. • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible for up to 60 days per calendar year • Covered at 60%, subject to the deductible • Covered at 80%, subject to the deductible
<p>Emergency Care</p> <ul style="list-style-type: none"> • Emergency room care • Freestanding urgent care center • Ambulance 	<ul style="list-style-type: none"> • \$150 copay per visit, unless admitted within 24 hours • \$25 copay per visit • \$150 copay 	<ul style="list-style-type: none"> • \$150 copay per visit, unless admitted within 24 hours • Covered at 60%, subject to the deductible • \$150 copay

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<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"> • \$25 copay per visit • Covered in full • Covered at 80%, subject to the deductible • \$15 copay per visit • \$25 copay per visit 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible
<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"> • Covered at 80%, subject to the deductible for up to 30 days per calendar year • \$25 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider office. • Covered at 80%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per calendar year; limited to 2 admissions per lifetime. • \$25 copay per visit for up to 60 visits per calendar year 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible for up to 30 days per calendar year • Covered at 60%, subject to the deductible, for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider's office. • Covered at 60%, subject to the deductible for up to 7 days for detoxification and 30 days for rehabilitation per calendar year; limited to 2 admissions per lifetime. • Covered at 60%, subject to the deductible 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 • External prosthetics 	<ul style="list-style-type: none"> • \$15 copay for up to a 30 day supply • Covered at 80%, subject to the deductible for up to 45 days per calendar year • Covered in full for up to 40 visits per calendar year • Covered in full for unlimited days • \$25 copay for up to a combined total of 45 visits per calendar year for physical, speech and occupational therapy • Covered at 80% subject to the deductible for up to \$15,000 per calendar year combined with external prosthetics and orthotics • Covered at 80% subject to the deductible for up to \$15,000 per calendar year combined with DME and orthotics 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible for up to a 30 day supply • Covered at 60%, subject to the deductible for up to 45 days per calendar year • Covered at 75%, subject to a \$50 deductible for up to 40 visits per calendar year. • Covered at 60%, subject to the deductible for unlimited visits per calendar year • Covered at 60%, subject to the deductible for a combined total of 45 visits per calendar year for physical, speech, and occupational therapy • Covered at 60% subject to the deductible for up to \$15,000 per calendar year combined with external prosthetics and orthotics • Covered at 60% subject to the deductible for up to \$15,000 per calendar year combined with DME and orthotics



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<ul style="list-style-type: none"> • Chiropractic • Acupuncture • Dental • Hearing 	<ul style="list-style-type: none"> • \$25 copay per visit • \$25 copay for up to 10 visits per calendar year • \$25 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly • \$25 copay for one routine hearing exam per calendar year. Hearing aids covered up to \$600 every 3 years for children to age 19. 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible • Covered at 60%, subject to the deductible, for up to 10 visits per calendar year • Covered at 60%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly • Covered at 60%, subject to the deductible, for one routine hearing exam per calendar year. Hearing aids covered up to \$600 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. 3/10/2009

.\$500 cash back a year applies to each subscriber and adult spouse or domestic partner.