



**HealthyBlue 2009 - Copay and Deductible Option benefits**  
**Prepared for The Otsego Chamber of Commerce**

3/10/2009

Type of Care/Plan Benefits	In-Network	Out Of Network
<p><b>Plan features</b></p> <ul style="list-style-type: none"> <li>• Primary Care Physician (PCP)</li> <li>• Referrals</li> <li>• Out of network benefits</li> <li>• Out of area benefits</li> <li>• Student/Dependent coverage</li> <li>• Domestic partner</li> </ul> <p><b>Plan cost-sharing highlights</b></p> <ul style="list-style-type: none"> <li>• Office visit copay (Primary Care Physician)</li> <li>• Office visit copay (Specialist)</li> <li>• Coinsurance</li> <li>• Deductible</li> <li>• Out of pocket maximum</li> <li>• Lifetime maximum</li> </ul>	<ul style="list-style-type: none"> <li>• Not required</li> <li>• Not required</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Coverage provided worldwide through the BlueCard® program.</li> <li>• Qualified dependents are covered to age 19. Qualified students are covered to age 23.</li> <li>• Covered</li> </ul> <ul style="list-style-type: none"> <li>• Adult: \$15 Copay per visit; Children to age 19: \$0 Copay per visit</li> <li>• \$25 copay per visit</li> <li>• In-network: 20%; Out-of-network: 40%</li> <li>• Combined in and out of network: \$1,000 individual/\$3,000 family</li> <li>• Combined in and out-of-network: \$3,000 individual/\$9,000 family</li> <li>• None</li> </ul>	

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<p><b>HealthyRewards</b></p> <ul style="list-style-type: none"> <li>• Earn cash back with HealthyRewards</li> </ul> <p><b>Preventive Health Care Services</b></p> <ul style="list-style-type: none"> <li>• Well child visits</li> <li>• Adult routine physical exams</li> <li>• Adult immunizations</li> <li>• Mammography</li> <li>• Pap smear</li> <li>• Routine GYN exam</li> <li>• Prostate cancer screening</li> <li>• Routine vision</li> <li>• Colonoscopy</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Covered in full</li> <li>• Covered in full for 1 exam per calendar year</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• \$25 copay for one routine exam every year; \$60 eyewear allowance available per calendar year</li> <li>• Preventive covered in full, diagnostic covered according to the surgical benefit</li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full</li> <li>• Covered at 60%, subject to the deductible for one routine exam per calendar year</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible for one routine exam per calendar year</li> <li>• Covered at 60%, subject to the deductible</li> </ul>

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<p><b>Physician Office Services</b></p> <ul style="list-style-type: none"> <li>• <b>Diagnostic office visits</b></li> <li>• <b>Diagnostic x-rays</b></li> <li>• <b>Diagnostic laboratory and pathology</b></li> <li>• <b>Allergy tests</b></li> <li>• <b>Allergy injections</b></li> <li>• <b>Chemotherapy</b></li> <li>• <b>Radiation therapy</b></li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• \$25 copay per visit</li> <li>• Covered in full</li> <li>• 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.</li> <li>• 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.</li> <li>• \$15 copay per visit</li> <li>• \$25 copay per visit</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> </ul>
<p><b>Maternity Services</b></p> <ul style="list-style-type: none"> <li>• <b>Prenatal and postpartum care</b></li> <li>• <b>Hospital care for mom (including delivery)</b></li> <li>• <b>Newborn nursery care</b></li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 80%, subject to the deductible</li> <li>• Covered at 80%, subject to the deductible</li> <li>• Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> </ul>
<p><b>Prescription Drug</b></p> <ul style="list-style-type: none"> <li>• <b>Short-term and maintenance drugs</b></li> </ul>	<ul style="list-style-type: none"> <li>• \$5/\$25/\$50; \$0 copay for generics for children to age 19.</li> </ul>	<ul style="list-style-type: none"> <li>• Not covered</li> </ul>
<p><b>Inpatient Hospital Benefits</b></p> <ul style="list-style-type: none"> <li>• <b>Hospital benefits</b></li> <li>• <b>Physician visits in the hospital</b></li> <li>• <b>Inpatient physical rehabilitation</b></li> <li>• <b>Surgery</b></li> <li>• <b>Anesthesia</b></li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 80%, subject to the deductible.</li> <li>• Covered at 80%, subject to the deductible</li> <li>• Covered at 80%, subject to the deductible for up to 60 days per calendar year</li> <li>• Covered at 80%, subject to the deductible</li> <li>• Covered at 80%, subject to the deductible</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 60%, subject to the deductible.</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible for up to 60 days per calendar year</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 80%, subject to the deductible</li> </ul>
<p><b>Emergency Care</b></p> <ul style="list-style-type: none"> <li>• <b>Emergency room care</b></li> <li>• <b>Freestanding urgent care center</b></li> <li>• <b>Ambulance</b></li> </ul>	<ul style="list-style-type: none"> <li>• \$150 copay per visit, unless admitted within 24 hours</li> <li>• \$25 copay per visit</li> <li>• \$150 copay</li> </ul>	<ul style="list-style-type: none"> <li>• \$150 copay per visit, unless admitted within 24 hours</li> <li>• Covered at 60%, subject to the deductible</li> <li>• \$150 copay</li> </ul>

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<p><b>Outpatient Hospital Benefits</b></p> <ul style="list-style-type: none"> <li>• <b>Diagnostic x-rays</b></li> <li>• <b>Diagnostic laboratory and pathology</b></li> <li>• <b>Surgical care</b></li> <li>• <b>Chemotherapy</b></li> <li>• <b>Radiation therapy</b></li> </ul>	<ul style="list-style-type: none"> <li>• \$25 copay per visit</li> <li>• Covered in full</li> <li>• Covered at 80%, subject to the deductible</li> <li>• \$15 copay per visit</li> <li>• \$25 copay per visit</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> <li>• Covered at 60%, subject to the deductible</li> </ul>
<p><b>Mental Health and Chemical Dependence</b></p> <ul style="list-style-type: none"> <li>• <b>Inpatient mental health care</b></li> <li>• <b>Outpatient mental health care</b></li> <li>• <b>Inpatient chemical dependence</b></li> <li>• <b>Outpatient chemical dependence</b></li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 80%, subject to the deductible for up to 30 days per calendar year</li> <li>• \$25 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider office.</li> <li>• 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.</li> <li>• \$25 copay per visit for up to 60 visits per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 60%, subject to the deductible for up to 30 days per calendar year</li> <li>• 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.</li> <li>• 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.</li> <li>• Covered at 60%, subject to the deductible for up to 60 visits per calendar year</li> </ul>
<p><b>Other Services</b></p> <ul style="list-style-type: none"> <li>• <b>Diabetic insulin and supplies</b></li> <li>• <b>Skilled nursing facility</b></li> <li>• <b>Home care</b></li> <li>• <b>Hospice</b></li> <li>• <b>Outpatient therapy</b></li> <li>• <b>Durable medical equipment</b></li> <li>• <b>External prosthetics</b></li> </ul>	<ul style="list-style-type: none"> <li>• \$15 copay for up to a 30 day supply</li> <li>• Covered at 80%, subject to the deductible for up to 45 days per calendar year</li> <li>• Covered in full for up to 40 visits per calendar year</li> <li>• Covered in full for unlimited days</li> <li>• \$25 copay for up to a combined total of 45 visits per calendar year for physical, speech and occupational therapy</li> <li>• Covered at 80% subject to the deductible for up to \$15,000 per calendar year combined with external prosthetics and orthotics</li> <li>• Covered at 80% subject to the deductible for up to \$15,000 per calendar year combined with DME and orthotics</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 60%, subject to the deductible for up to a 30 day supply</li> <li>• Covered at 60%, subject to the deductible for up to 45 days per calendar year</li> <li>• Covered at 75%, subject to a \$50 deductible for up to 40 visits per calendar year.</li> <li>• Covered at 60%, subject to the deductible for unlimited visits per calendar year</li> <li>• Covered at 60%, subject to the deductible for a combined total of 45 visits per calendar year for physical, speech, and occupational therapy</li> <li>• Covered at 60% subject to the deductible for up to \$15,000 per calendar year combined with external prosthetics and orthotics</li> <li>• Covered at 60% subject to the deductible for up to \$15,000 per calendar year combined with DME and orthotics</li> </ul>



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

\*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.