

Comparison of benefits for Webster Chamber - 2010

11/20/2009

type of care/plan features	Blue Choice Select	Blue Choice Value	Blue Choice \$25 Copay Option
	Coverage	Coverage	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 Out of pocket maximum Lifetime maximum <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 <p>Physician Office Services</p> <ul style="list-style-type: none"> Diagnostic office visits 	<ul style="list-style-type: none"> Required Required Not covered Emergency coverage provided worldwide through the BlueCard® program. Qualified dependents and students are covered to age 26. Covered \$15 copay \$15 copay None None None None None Covered in full \$15 copay per visit \$15 copay \$15 copay \$15 copay \$15 copay \$15 copay \$15 copay for 1 routine exam every 2 years; every year for children to age 19. \$60 eyewear allowance available every 2 years; every year for children to age 19. Preventive and diagnostic covered according to the surgical benefit \$15 copay per visit; \$5 copay for sick children to age 5. 	<ul style="list-style-type: none"> Required Required Not covered Emergency coverage provided worldwide through the BlueCard® program. Qualified dependents and students are covered to age 26. Covered \$20 copay \$20 copay None None None None None Covered in full \$20 copay per visit \$20 copay per visit \$20 copay \$20 copay \$20 copay \$20 copay \$20 copay per visit \$20 copay for one routine exam every 2 years; every year for children to age 19. \$60 eyewear allowance available every 2 years; every year for children to age 19. Preventive and diagnostic covered according to the surgical benefit \$20 copay per visit 	<ul style="list-style-type: none"> Required Required Not covered Emergency coverage provided worldwide through the BlueCard® program. Qualified dependents and students are covered to age 26. Covered \$25 copay \$40 copay None None None None Covered in full \$25 copay per visit \$25 copay \$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. Eyewear \$60 allowance every 2 years; every year for children to age 19. Preventive and diagnostic covered according to the surgical benefit \$25 copay per visit

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<ul style="list-style-type: none"> Diagnostic x-rays Diagnostic laboratory and pathology Allergy tests Allergy injections Chemotherapy Radiation therapy 	<ul style="list-style-type: none"> \$15 copay per visit Covered in full \$15 copay per visit \$15 copay per visit \$15 copay for IV/injectable chemotherapy, in addition to a \$15 copay for the office visit Covered in full 	<ul style="list-style-type: none"> \$20 copay per visit Covered in full \$20 copay per visit \$20 copay per visit \$20 copay for IV/injectable chemotherapy, in addition to a \$20 copay for the office visit \$20 copay per visit 	<ul style="list-style-type: none"> \$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 for IV/injectable chemotherapy, in addition to a \$25 copay for the office visit \$25 copay per visit
<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"> \$5 copay per visit for first 10 visits, remainder of visits are covered in full Covered in full Covered in full 	<ul style="list-style-type: none"> \$5 copay per visit for first 10 visits, remainder of visits are covered in full Hospital-Subject to \$100 copay per admission; Delivery-Subject to 20% coinsurance or \$100 copay, whichever is less Covered in full 	<ul style="list-style-type: none"> \$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
<p>Prescription Drug</p>			
<ul style="list-style-type: none"> Short-term and maintenance drugs 	<ul style="list-style-type: none"> \$5/\$20/\$35 	<ul style="list-style-type: none"> \$10/\$25/\$40 	<ul style="list-style-type: none"> \$7 copay for generics only
<p>Inpatient Hospital Benefits</p>			
<ul style="list-style-type: none"> Hospital benefits Physician visits in the hospital Inpatient physical rehabilitation Surgery 	<ul style="list-style-type: none"> Covered in full for unlimited days Covered in full Covered at 100% for up to 60 days per calendar year Covered in full Covered in full 	<ul style="list-style-type: none"> Subject to \$100 copay per admission for unlimited days Covered in full Subject to \$100 copay per admission for 60 days per calendar year Facility: Subject to \$100 copay; Physician: Subject to 20% coinsurance or \$100 copay, whichever is less Covered in full 	<ul style="list-style-type: none"> Subject to \$500 copay per admission for unlimited days Covered in full Not covered Facility: Subject to \$500 copay; Physician: Subject to 20% coinsurance or \$200 copay, whichever is less Covered in full
<ul style="list-style-type: none"> Anesthesia 	<ul style="list-style-type: none"> 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"> \$50 copay per visit, unless admitted within 24 hours \$25 copay per visit \$25 copay 	<ul style="list-style-type: none"> \$50 copay per visit, unless admitted within 24 hours \$25 copay per visit \$50 copay 	<ul style="list-style-type: none"> \$100 copay per visit, unless admitted within 24 hours \$35 copay per visit \$100 copay

type of care/plan features	Blue Choice Select Coverage	Blue Choice Value Coverage	Blue Choice \$25 Copay Option Coverage
<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 • Hospice • Outpatient therapy • Durable medical equipment • External prosthetics • Chiropractic • Acupuncture • Dental 	<ul style="list-style-type: none"> • \$15 copay per visit • Covered in full • \$15 copay • \$15 copay for IV/injectable chemotherapy, in addition to a \$15 copay for the office visit • Covered in full • Covered in full for up to 30 days per calendar year • \$15 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider office. • Covered in full for up to 7 days per calendar year for detoxification only • \$15 copay per visit for up to 60 visits per calendar year • \$15 copay for up to a 30 day supply • Covered in full for up to 120 days per calendar year; 360 days per lifetime • Covered in full for unlimited visits • Covered in full for unlimited days • \$15 copay per visit for up to a combined total of 30 visits per calendar year for physical, speech, respiratory and occupational therapy • Covered at 80% up to \$5,000 per calendar year • Covered at 80%, up to \$15,000 per calendar year • \$15 copay per visit • Covered at 50% for up to 10 visits per calendar year • \$15 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly 	<ul style="list-style-type: none"> • \$20 copay per visit • Covered in full • Facility: \$50 copay; Physician: \$20 copay • \$20 copay for IV/injectable chemotherapy, in addition to a \$20 copay for the office visit • \$20 copay per visit • Subject to \$100 copay per admission for up to 30 days per calendar year • \$20 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider office. • Subject to \$100 copay per admission for up to 7 days for detoxification and 30 days for rehabilitation per calendar year • \$20 copay per visit for up to 60 visits per calendar year • \$20 copay for up to a 30 day supply • Covered in full for up to 120 days per calendar year; 360 days per lifetime • Covered in full for unlimited visits • Covered in full for unlimited days • \$20 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% up to \$5,000 per calendar year • Covered at 50% up to \$15,000 per calendar year • \$20 copay per visit • Covered at 50% for up to 10 visits per calendar year • \$20 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly 	<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 for IV/injectable chemotherapy, in addition to a \$25 copay for the office visit • \$25 copay per visit • Subject to \$500 copay per admission for up to 30 days per calendar year • \$40 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider office. • Not covered • \$25 copay per visit for up to 60 visits per calendar year • \$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 • Not covered • \$40 copay per visit for up to a combined total of 30 visits per calendar year for physical, speech, occupational and respiratory therapy • Not covered • Not covered • \$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

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<ul style="list-style-type: none"> Hearing 	<ul style="list-style-type: none"> Hearing aids covered up to \$600 for up to 2 hearing aids every 3 years for children to age 19 	<ul style="list-style-type: none"> Hearing aids covered up to \$600 for up to 2 hearing aids every 3 years for children to age 19 	<ul style="list-style-type: none"> Hearing aids covered up to \$600 for up to 2 hearing aids every 3 years for children to age 19