

## Medical Benefit Comparison

This information provides a comparison of the major provisions of each medical plan -- it is not a contract. It is intended to highlight the coverage of the various plans; benefits are determined by the terms of the contract. If there is any confusion or conflict regarding plan features, the governing plan document/contract will be the final authority. The University intends to continue these benefit plans indefinitely, but reserves the right to modify or terminate such plans at any time with or without notice. Participation in these plans is provided to eligible retirees, surviving spouses and those on LTD and requires continued eligibility and is subject to the terms and conditions of the Plan Documents.

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## General Information

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Medicare Blue Choice and Preferred Gold are for retirees who live in the Rochester area at least six months of the year. The Blue PPO plan is for retirees who live outside the Rochester area. The BCBS Comprehensive is closed to new enrollments effective January 1, 2010.

### Plan Availability

<b>Medicare Blue Choice</b>	Available to retirees who live in the Rochester area at least six months of the year.
<b>Preferred Gold</b>	Available to retirees who live in the Rochester area at least six months of the year.
<b>Blue PPO</b>	Available to retirees who live outside the Rochester area.
<b>BCBS Comprehensive</b>	Available to retirees who were enrolled as of December 31, 2009. Closed to new enrollments beginning January 1, 2010.

### Contacting the Carrier

<b>Medicare Blue Choice</b>	Voice: (877) 883-9577 TTY: (585) 454-2845 Website: <a href="http://www.excellusbcb.com">www.excellusbcb.com</a>
<b>Preferred Gold</b>	Voice: (800) 665-7924 TTY: (800) 252-2452 Website: <a href="http://www.mvphealthcare.com">www.mvphealthcare.com</a>
<b>Blue PPO</b>	Voice: (877) 668-7636 TTY: (585) 454-2845 Website: <a href="http://www.excellusbcb.com">www.excellusbcb.com</a>
<b>BCBS Comprehensive</b>	Voice: (877) 668-7636 TTY: (585) 454-2845 Website: <a href="http://www.excellusbcb.com">www.excellusbcb.com</a>

### Deductible Carry Over

<b>Medicare Blue Choice</b>	None.
<b>Preferred Gold</b>	None.
<b>Blue PPO</b>	Yes; if you have not met your deductible during the calendar year and have claims for expenses during the last calendar quarter (October-December), the last quarter's expenses will be applied toward the next calendar year's deductible.
<b>BCBS Comprehensive</b>	None.

## Deductible, Coinsurance, Annual Out of Pocket Maximum

<b>Medicare Blue Choice</b>	No annual deductible or annual out of pocket maximum. Coinsurance only applies to benefits noted.
<b>Preferred Gold</b>	No annual deductible. Coinsurance only applies to benefits noted. \$4,000 annual out of pocket maximum (excludes Rx).
<b>Blue PPO</b>	<p>Annual deductible of \$500 per member per calendar year (applies to both participating and non-participating providers). After you have paid the deductible, the plan pays:</p> <ul style="list-style-type: none"> <li>• 80% of covered services for <u>participating providers</u>, and</li> <li>• 70% of covered services for <u>non-participating providers</u>.</li> </ul> <p>You pay the remaining portion of coinsurance for covered services, until you reach the Annual Out-of-Pocket Maximum (see below); then the plan pays 100% of most covered services for the remainder of the calendar year.</p> <p>Your annual out-of-pocket maximum is \$1,250 per member (\$500 deductible plus \$750 coinsurance; (applies to both participating and non-participating providers). After this annual out of pocket maximum has been reached, the plan pays 100% of most covered services for the remainder of the calendar year.</p>
<b>BCBS Comprehensive</b>	Annual deductible of \$350 per member per calendar year. After you have paid the deductible, the Plan pays 80% of covered services, you pay 20% of covered services, until you reach the Annual Out of Pocket Maximum of \$1,350 (\$350 deductible plus \$1,000 coinsurance); then plan pays 100% of most covered services for the remainder of the calendar year.

## Services (sorted alphabetically)

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### Acupuncture

<b>Medicare Blue Choice</b>	Not covered.
<b>Preferred Gold</b>	Covered at 50% for up to 10 visits per member per calendar year.
<b>Blue PPO</b>	<p><b>Participating:</b> Covered at 50% for up to 10 visits per member per calendar year. (combined total)</p> <p><b>Not Participating:</b> Covered at 50%, subject to deductible, for up to 10 visits per member per calendar year. (combined total)</p>
<b>BCBS Comprehensive</b>	Covered at 80%, subject to the deductible, less Medicare payment, if any, when medically necessary.

## Allergy Tests & Injections

Medicare Blue Choice	\$20 copay per visit. Serum covered in full.
Preferred Gold	\$15 copay per Primary Care Physician visit. \$30 copay per Specialist visit. Serum covered in full.
Blue PPO	<u>Tests:</u> <b>Participating:</b> \$15 per visit <b>Not Participating:</b> Covered at 70%, subject to deductible. <u>Injections:</u> <b>Participating:</b> Covered in full <b>Not Participating:</b> Covered at 70%, subject to deductible.
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any.

## Ambulance

Medicare Blue Choice	\$50 copay.
Preferred Gold	\$50 copay per service when medical treatment is required during transport.
Blue PPO	<b>Participating:</b> \$50 copay <b>Not Participating:</b> \$50 copay
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any, when medically necessary.

## Chemical Dependence-Inpatient

Medicare Blue Choice	\$250 facility copay, unlimited days of hospital and physician care.
Preferred Gold	Unlimited days of hospital and physician care subject to the inpatient copay of \$250; (Limit of 3 copays per calendar year, or \$750).
Blue PPO	<b>Participating:</b> Covered at 80%, subject to deductible for up to 7 days of hospital and physician care per member per calendar year for detoxification only. Two admissions per lifetime. <b>Not Participating:</b> Covered at 70%, subject to deductible for up to 7 days of hospital and physician care per member per calendar year for detoxification only. Two admissions per lifetime.
BCBS Comprehensive	Admissions for detoxification are covered under the In-Hospital medical benefit. Admissions for rehabilitation are covered at 80%, subject to the deductible, less Medicare payment, if any, for up to 45 days per member per calendar year. Two occurrences per lifetime.

## Chemical Dependence-Outpatient

Medicare Blue Choice	45% coinsurance per visit.
Preferred Gold	Covered with a copayment of \$30.
Blue PPO	<b>Participating:</b> Covered at 80%, subject to deductible for up to 60 visits per calendar year, 20 of which can be used for family therapy. <b>Not Participating:</b> Covered at 70%, subject to deductible for up to 60 visits per calendar year, 20 of which can be used for family therapy.
BCBS Comprehensive	60 outpatient facility visits per member per calendar year, covered at 80%, subject to the deductible, less Medicare payment.  Professional charges and outpatient facility visits beyond the initial 60 visits are covered at 80%, subject to the deductible, less Medicare payment, if any, up to the 25 visit psychiatric maximum.

## Chemotherapy

Medicare Blue Choice	\$20 copay per visit.
Preferred Gold	\$30 copay per visit (professionally administered)
Blue PPO	<b>Participating:</b> Covered at 80% subject to deductible. <b>Not Participating:</b> Covered at 70%, subject to deductible.
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any.

## Chiropractic Services

Medicare Blue Choice	\$20 copay per visit, for manual manipulation of the spine only, according to Medicare guidelines.
Preferred Gold	\$30 copay per visit; per Medicare guidelines.
Blue PPO	<b>Participating:</b> \$15 copay per visit <b>Not Participating:</b> Covered at 70%, subject to deductible.
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any, up to \$800 per member per calendar year.

## Dental

Medicare Blue Choice	Covered when related to an accidental injury to sound, natural teeth.
Preferred Gold	\$30 copay; when related to an accidental injury to sound, natural teeth.
Blue PPO	Covered when related to an accidental injury to sound, natural teeth.
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any, for treatment of an accidental injury to sound and natural teeth, within 12 months of the accident. Limited to \$500 per injury. Select oral surgery procedures included.

## Durable Medical Equipment (DME)

<b>Medicare Blue Choice</b>	Covered at 80% with no deductible at network providers.
<b>Preferred Gold</b>	Covered at 80% with no deductible at network providers.
<b>Blue PPO</b>	<b>Participating:</b> Standard equipment covered at 80%, subject to deductible. <b>Not Participating:</b> Standard equipment covered at 70%, subject to deductible.
<b>BCBS Comprehensive</b>	Covered at 100% of the Schedule of Allowances, subject to the deductible, less Medicare payment, if any, when ordered by your physician and obtained from a Participating Provider. If DME is obtained from a Non-Participating Provider, it will be covered at 50% of the charge, subject to the deductible, less Medicare payment, if any.

## Emergency Care

<b>Medicare Blue Choice</b>	\$50 copay; waived if admitted for Emergency Care.
<b>Preferred Gold</b>	\$50 copay medical emergencies; waived if admitted.
<b>Blue PPO</b>	<b>Participating:</b> Emergency Room - \$50 per visit unless admitted within 24 hours. <b>Not Participating:</b> Emergency Room - \$50 per visit unless admitted within 24 hours.
<b>BCBS Comprehensive</b>	Covered at 80%, subject to the deductible, less Medicare payment, if any.

## Eye Exams and Eyewear

<b>Medicare Blue Choice</b>	\$20 copay for routine eye exams, once every year. \$60 material allowance for eyeglasses and contact lenses every year. 20% coinsurance after cataract surgery. 25% discount at participating network providers.
<b>Preferred Gold</b>	<p>\$30 copay for routine and diagnostic eye exams, once every year.</p> <p><i>Eyeglasses after cataract surgery:</i> Covered at 80% at network providers.</p> <p><i>Routine purchase of eyeglasses:</i> Covered with a 20% to 60% discount and a \$100 annual eyewear allowance at network providers.</p>
<b>Blue PPO</b>	<p><u>Exams:</u></p> <p><b>Participating:</b> \$15 copay for routine eye exams, once every 2 years. \$15 copay for eye exams associated with disease or injury.</p> <p><b>Not Participating:</b> Covered at 70%, subject to deductible.</p> <p><u>Eyewear:</u></p> <p><b>Participating:</b> \$60 allowance toward the purchase of one pair of eyeglasses or contact lenses through a participating provider once every 2 years. One pair of corrective lenses after cataract surgery covered in full.</p> <p><b>Not Participating:</b> \$60 allowance toward the purchase of one pair of eyeglasses or contact lenses through a participating provider once every 2 years. One pair of corrective lenses after cataract surgery covered at 70%, subject to the deductible.</p>
<b>BCBS Comprehensive</b>	No coverage for routine exams or refractions. Diagnostic exams covered at 80%, subject to the deductible, less Medicare payment, if any. One pair of Eyeglasses/Contact lenses covered at 80%, subject to the deductible, only after cataract surgery, less Medicare payment, if any.

## Health and Wellness

<b>Medicare Blue Choice</b>	Go Getters Flexible Fitness benefit of \$650. With Go Getters, you'll have a \$650 annual benefit to use for fitness and weight loss programs, with the freedom to go wherever and whenever you want, accepted nationwide.
<b>Preferred Gold</b>	Up to \$100 annually in <b>HealthDollars</b> to use toward health programs such as weight loss and smoking cessation (any unused portion of this benefit cannot be carried over from one calendar year to the next.). The <b>SilverSneakers®</b> Fitness Program provides free fitness center membership benefits at a participating fitness center near you, including use of equipment and other amenities, at no charge. <b>You're in Charge!</b> provides free health education programs and support services to help you improve or maintain your health and independence, including classes on exercise and fitness, healthier eating, improving memory, preventing falls and improving balance, skills for living with diabetes, grief support, living with a chronic condition, and more.
<b>Blue PPO</b>	Not applicable.
<b>BCBS Comprehensive</b>	Not applicable.

## Hearing Evaluations & Hearing Aids

<b>Medicare Blue Choice</b>	\$20 copay per visit for exam, and \$300 Hearing Aid allowance every 3 years.
<b>Preferred Gold</b>	Routine Hearing Evaluations covered with a \$30 copay. \$600 Hearing Aid allowance every 3 years.
<b>Blue PPO</b>	<b>Participating:</b> Routine evaluations and hearing aids not covered. Diagnostic exams covered at 80% subject to deductible. <b>Not Participating:</b> Routine evaluations and hearing aids not covered. Diagnostic exams covered at 70% subject to deductible.
<b>BCBS Comprehensive</b>	No coverage for routine care. Diagnostic exams covered at 80%, subject to the deductible, less Medicare payment, if any. Hearing aids are covered at 80% of the reasonable charge, subject to the deductible. Allowance is 2 per lifetime, \$700 maximum each.

## Home Care

Medicare Blue Choice	Covered in full.
Preferred Gold	Covered in full for visits 1-20, excluding custodial care. \$30 co-pay per day visits 21+.
Blue PPO	<b>Participating:</b> Covered at 80%, subject to \$50 deductible for unlimited days <b>Not Participating:</b> Covered at 75%, subject to \$50 deductible for unlimited days
BCBS Comprehensive	Services covered at 80%, subject to the deductible, less Medicare payment, if any.

## Hospice

Medicare Blue Choice	Covered in full for the same number of approved Medicare days.
Preferred Gold	Covered by original Medicare.
Blue PPO	<b>Participating:</b> Covered at 80% for unlimited visits <b>Not Participating:</b> Covered at 70%, subject to deductible for unlimited visits
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any.

## Hospital Pre-admission Testing

Medicare Blue Choice	Covered in full.
Preferred Gold	Covered in full.
Blue PPO	<b>Participating:</b> Covered at 80% subject to deductible. <b>Not Participating:</b> Covered at 70%, subject to deductible.
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any.

## Hospital Services-Inpatient

Medicare Blue Choice	\$250 copay per admission (limit 2 copays per calendar year or \$500). Services include physician visits, anesthesia and surgery.
Preferred Gold	\$250 copay per admission (limit 3 copays per calendar year, or \$750). Services include physician visits, anesthesia and surgery.
Blue PPO	<b>Participating:</b> Covered at 80% subject to deductible <b>Not Participating:</b> Covered at 70%, subject to deductible. Services include physician visits, anesthesia and surgery.
BCBS Comprehensive	Unlimited days for semi-private room and all services for acute care covered at 80%, subject to the deductible, less Medicare payment, if any. Private room covered when medically necessary. Services include physician visits, anesthesia and surgery.

## Laboratory & Pathology - Diagnostic

Medicare Blue Choice	Covered in full.
Preferred Gold	Covered in full.
Blue PPO	<b>Participating:</b> Covered at 80% subject to deductible. <b>Not Participating:</b> Covered at 70%, subject to deductible.
BCBS Comprehensive	Covered at 80% of the Schedule of Allowances, subject to the deductible, less Medicare payment, if any.

## Mental Health-Inpatient

Medicare Blue Choice	Covered with a \$250 copayment, maximum of two visit per year. Up to 190 days of non-renewable coverage per lifetime in psychiatric hospital.
Preferred Gold	Unlimited days of acute hospital and physician care subject to the inpatient copay of \$250. (Limit of 3 copays per calendar year , or \$750). Up to 190 days of non-renewable coverage per lifetime in a psychiatric hospital.
Blue PPO	<b>Participating:</b> Covered at 80%, subject to deductible for up to 30 days of hospital and physician care per member per calendar year. <b>Not Participating:</b> Covered at 70%, subject to deductible for up to 30 days of hospital and physician care per member per calendar year.
BCBS Comprehensive	45 days of hospital and physician care covered at 80%, subject to the deductible, less Medicare payment, if any.

## Mental Health-Outpatient

Medicare Blue Choice	50% copay per visit. No maximum number of visits.
Preferred Gold	Covered with a \$30 copay. No maximum number of visits.
Blue PPO	<b>Participating:</b> Covered with a \$15 copay for up to 20 visits per member per calendar year. <b>Not Participating:</b> Covered at 75%, subject to the deductible for up to 20 visits per member per calendar year.
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any, up to 25 visits per member per year.

## Occupational Therapy

<b>Medicare Blue Choice</b>	\$20 copay per visit.
<b>Preferred Gold</b>	\$30 copay per visit. The plan will pay a maximum of \$1,840 per calendar year for Occupational Therapy.
<b>Blue PPO</b>	<p><b>Participating:</b> Covered at 80%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory, and speech therapy per member per calendar year in and out of network combined.</p> <p><b>Not Participating:</b> Covered at 70%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory, and speech therapy per member per calendar year in and out of network combined.</p>
<b>BCBS Comprehensive</b>	Covered at 80%, subject to the deductible, less Medicare payment, if any. No coverage for supplies.

## Out of Area Coverage

<b>Medicare Blue Choice</b>	Coverage provided worldwide when life-threatening or authorized by your Primary Care Physician; travel benefit covers routine care outside service area (see Travel Benefit in next section).
<b>Preferred Gold</b>	Worldwide urgent or emergency care covered as in-network; travel benefit covers routine care outside service area (see Travel Benefit in next section).
<b>Blue PPO</b>	Coverage provided worldwide.
<b>BCBS Comprehensive</b>	Coverage provided worldwide.

## Physician Visit – In Office, Diagnostic (ill or injured)

<b>Medicare Blue Choice</b>	\$20 co-pay for Primary Care Physician and \$20 co-pay for Specialist visit.
<b>Preferred Gold</b>	\$15 copay per Primary Care Physician visit. \$30 copay per specialist visit.
<b>Blue PPO</b>	<p><b>Participating:</b> \$15 per visit</p> <p><b>Not Participating:</b> Covered at 70%, subject to deductible.</p>
<b>BCBS Comprehensive</b>	Covered at 80%, subject to the deductible, less Medicare payment, if any.

## Physician Visits – In Office, Routine Preventive Services

<b>Medicare Blue Choice</b>	Periodic routine physicals, annual pelvic exam, Pap Smear, periodic routine mammograms and bone mass covered in full.
<b>Preferred Gold</b>	Periodic routine physicals covered with a \$15 copayment per visit for PCP. Annual pelvic exam and Pap Smear covered in full. Office visit copay may apply. Periodic routine mammograms covered in full. Pneumococcal, Influenza and Hepatitis B vaccinations or immunizations covered in full.
<b>Blue PPO</b>	<p><b>Participating:</b> Periodic routine physicals covered, \$15 copay per visit, according to National Medical Specialty recommended schedule. Annual pelvic exams, Pap Smears for women aged 18 and older covered in full. Routine mammograms are covered in full.</p> <p><b>Not Participating:</b> Periodic routine physicals covered at 70%, subject to the deductible, according to National Medical Specialty recommended schedule. Annual pelvic exams, Pap Smears for women aged 18 and older covered at 70%, subject to the deductible. Routine mammograms covered at 70%, subject to the deductible.</p>
<b>BCBS Comprehensive</b>	<p>No coverage for routine physical exams.</p> <p>Periodic routine pap smears covered at 80% of the Schedule of Allowances, subject to the deductible, less Medicare payment, if any.</p> <p>Periodic routine mammograms covered at 80% of the Schedule of allowances, subject to the deductible, less Medicare payment, if any.</p>

## Podiatry

<b>Medicare Blue Choice</b>	\$20 copay per visit. No coverage for routine foot care.
<b>Preferred Gold</b>	\$30 copay per visit.
<b>Blue PPO</b>	Participating: \$15 copay per visit. No coverage for routine foot care.
<b>BCBS Comprehensive</b>	Covered at 80%, subject to the deductible, less Medicare payment, if any. No coverage for routine foot care.

## Physical Therapy

<b>Medicare Blue Choice</b>	\$20 copay per visit.
<b>Preferred Gold</b>	\$30 copay per visit. The plan will pay a maximum of \$1,840 per calendar year for physical therapy and speech therapy, combined.
<b>Blue PPO</b>	<p><b>Participating:</b> Covered at 80%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory, and speech therapy per member per calendar year in and out of network combined.</p> <p><b>Not Participating:</b> Covered at 70%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory, and speech therapy per member per calendar year in and out of network combined.</p>
<b>BCBS Comprehensive</b>	Covered at 80%, subject to the deductible, less Medicare payment, if any.

## Prescription Drugs Covered Under Medical Plan

Medicare Blue Choice  
Blue PPO  
BCBS Comprehensive

**Local Pharmacy:** Short-term and maintenance medication can be purchased at the local pharmacy with the copay amounts as follows.

**Mail Order Maintenance:** Certain types of medications can be purchased by mail order in up to a 90-day supply for the copays shown below. If you purchase a 90-day supply at the local retail pharmacy, the copay will be 3 times the 30-day supply copay amount. The Excellus mail order pharmacy is with Express Scripts.

There are three categories of prescription medication with different copay amounts.

	RETAIL 30-day supply	MAIL ORDER 90-day supply
<u>Tier 1:</u>		
generic drugs	\$10	\$30
<u>Tier 2:</u>		
Excellus' formulary brand name drugs	\$25	\$75
<u>Tier 3:</u>		
non-formulary brand name drugs	\$40	\$120

Medicare Part B drugs and diabetic supplies covered at 80%.

**NOTE about catastrophic protection:** If your total copays during a calendar year exceed \$4,550, then for the rest of the calendar year, you will pay reduced copays as follows:

- Generic – the greater of 5% of the drug's cost or \$2.15
- Brand Name – the greater of 5% of the drug's cost or \$5.35

This provision applies to drugs purchased at both retail and mail order pharmacies.

In cases of selected brand name drugs where an FDA-approved generic is available, your benefit will be based on the generic drug's cost. If you or your doctor choose the brand-name drug, you will have to pay the difference, plus any applicable copays. If your prescription does not have an approved generic substitute, your benefit will not be affected.

## Preferred Gold

**Local Pharmacy:** Short-term and maintenance medication can be purchased at the local pharmacy with the copay amounts as follows.

**Mail Order Maintenance:** Certain types of medications can be purchased by mail order in up to a 90-day supply for the copays shown below. The 90-day copay amounts are available only by mail order. If you purchase a 90-day supply at the local retail pharmacy, the copay will be 3 times the 30-day supply copay amount.

There are five categories of prescription medication with different copay amounts. **NOTE:** the 90-day supply copays are for Mail Order only. The Preferred Gold mail order pharmacy is with Medco.

	RETAIL <u>30-day supply</u>	MAIL ORDER <u>90-day supply</u>
<u>Tier 1:</u>		
Most generics	\$10	\$20
<u>Tier 2:</u>		
Preferred drugs	\$25	\$50
<u>Tier 3:</u>		
Non-preferred drugs	\$40	\$80
<u>Tier 4:</u>		
Specialty drugs	\$40	\$80
<u>Tier 5:</u>		
Limited/restricted drugs	\$40	\$80

Diabetic supplies covered at 80%.

**NOTE about catastrophic protection:** If your total copays during a calendar year exceed \$3,850, then for the rest of the calendar year, you will pay reduced copays as follows:

- Generic – the greater of 5% of the drug's cost or \$2.50
- Brand Name – the greater of 5% of the drug's cost or \$6.30

This provision applies to drugs purchased at both retail and mail order pharmacies.

In cases of selected brand name drugs where an FDA-approved generic is available, your benefit will be based on the generic drug's cost. If you or your doctor choose the brand-name drug, you will have to pay the difference, plus any applicable copays. If your prescription does not have an approved generic substitute, your benefit will not be affected.

## Private Duty Nursing

Medicare Blue Choice	Covered in full when medically necessary and approved in advance by the Primary Care Physician.
Preferred Gold	Covered in full when medically necessary and approved in advance by the Primary Care Physician.
Blue PPO	No coverage
BCBS Comprehensive	Covered at 80%, subject to the deductible, up to \$3,000 per member per calendar year.

## Prosthetics (External) and Orthopedic Braces and Supports

Medicare Blue Choice	Covered at 80% with no deductible at network providers.
Preferred Gold	Covered at 80% with no deductible at network providers.
Blue PPO	<b>Participating:</b> Standard equipment covered at 80%, subject to the deductible, up to \$15,000 per member per calendar year <b>Not Participating:</b> Standard equipment covered at 70%, subject to the deductible, up to \$15,000 per member per calendar year
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any, up to \$15,000 per member per calendar year.

## Prosthetics (Internal)

Medicare Blue Choice	Covered at 80% with no deductible at network providers.
Preferred Gold	Covered in full with no deductible at network providers.
Blue PPO	<b>Participating:</b> Covered at 80% subject to deductible. <b>Not Participating:</b> Covered at 70%, subject to deductible.
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any.

## Radiation Therapy

Medicare Blue Choice	\$20 copay per visit.
Preferred Gold	Covered in full.
Blue PPO	<b>Participating:</b> Covered at 80% subject to deductible. <b>Not Participating:</b> Covered at 70%, subject to deductible.
BCBS Comprehensive	Covered at 80% of the Schedule of Allowances, subject to the deductible, less Medicare payment, if any.

## Respiratory Therapy

<b>Medicare Blue Choice</b>	\$20 copay per visit.
<b>Preferred Gold</b>	\$30 copay per visit.
<b>Blue PPO</b>	<p><b>Participating:</b> Covered at 80%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory, and speech therapy per member per calendar year in and out of network combined.</p> <p><b>Not Participating:</b> Covered at 70%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory, and speech therapy per member per calendar year in and out of network combined.</p>
<b>BCBS Comprehensive</b>	Covered at 80%, subject to the deductible, less Medicare payment, if any.

## Skilled Nursing Facility

<b>Medicare Blue Choice</b>	Days 1-20: Covered in full. Days 21-100: Covered at 50%.
<b>Preferred Gold</b>	Up to 100 days covered per benefit period in a semi-private room and all medically necessary services. The first 15 days covered in full. Days 16-100 covered with a \$65 copayment.
<b>Blue PPO</b>	<p><b>Participating:</b> Covered at 80%, subject to deductible for up to 120 days per admission in semi-private accommodations and all medically necessary services. 360 lifetime maximum. Custodial care is not covered</p> <p><b>Not Participating:</b> Covered at 70% subject to deductible for up to 120 days per admission in semi-private accommodations and all medically necessary services. 360 lifetime maximum. Custodial care is not covered.</p>
<b>BCBS Comprehensive</b>	Unlimited inpatient days for semi-private room and all services covered at 80%, subject to the deductible, less Medicare payment, if any. Custodial care is not covered.

## Speech Therapy

<b>Medicare Blue Choice</b>	\$20 copay per visit.
<b>Preferred Gold</b>	\$30 copay per visit. The plan will pay a maximum of \$1,840 per calendar year for physical therapy and speech therapy, combined.
<b>Blue PPO</b>	<p><b>Participating:</b> Covered at 80%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory, and speech therapy per member per calendar year in and out of network combined.</p> <p><b>Not Participating:</b> Covered at 70%, subject to the deductible for a combined 45 visit maximum on occupational, physical, respiratory, and speech therapy per member per calendar year in and out of network combined.</p>
<b>BCBS Comprehensive</b>	Covered at 80%, subject to deductible, less Medicare payment, if any.

## Travel Benefit

<b>Medicare Blue Choice</b>	<p>This benefit covers you when you for routine care when you are traveling outside the plan service area for up to six months. There is no deductible, 20% coinsurance up to \$5,000 annual maximum.</p> <p><u>Medical Services Covered</u> by the Travel Benefits include, but are not limited to, office visits, lab and x-rays, mammograms, chiropractic care, durable medical equipment, physical, speech and occupational therapies.</p> <p>With Medicare Blue Choice prior authorization, the following services are covered: hospitalization, home health care and outpatient surgery.</p> <p><u>Medical Services NOT covered</u> by the Travel Benefit include skilled nursing facility, mental health services, substance abuse, and prescription drug (Rx covered only in emergencies).</p> <p>Coverage for Urgent care is Nationwide and emergent care worldwide.</p>
<b>Preferred Gold</b>	<p>The Travel Benefit covers you when you are traveling outside of the Preferred Care service area for up to 6 months at a time. There is 30% coinsurance and \$5,000 annual maximum.</p> <p><u>Medical Services Covered</u> by the Travel Benefit include office visits, lab and x-ray, mammograms, chiropractic care, durable medical equipment, physical, speech and occupational therapies, hospitalization (prior authorization required), home health care (prior authorization required), outpatient surgery (prior authorization required)</p> <p><u>Medical Services NOT covered</u> by the Travel Benefit include skilled nursing facility, mental health services, substance abuse services, diabetic supplies (these should be obtained from a participating pharmacy)</p> <p>Urgent and emergency care is covered worldwide; it is not subject to the Travel Benefit coinsurance or maximum.</p>
<b>Blue PPO</b>	Not Applicable.
<b>BCBS Comprehensive</b>	Not Applicable.

## Urgent Care

<b>Medicare Blue Choice</b>	\$20 copay for urgent care center.
<b>Preferred Gold</b>	\$30 copay for urgently needed services.
<b>Blue PPO</b>	<b>Participating:</b> After Hours in physician's office - \$15 copay per visit. Freestanding Urgent Care Center - \$25 copay per visit. <b>Not Participating:</b> After Hours in physician's office – covered at 70%, subject to deductible. Freestanding Urgent Care Center - covered at 70%, subject to deductible.
<b>BCBS Comprehensive</b>	Covered at 80%, subject to the deductible, less Medicare payment, if any.

## X-Ray-Diagnostic

<b>Medicare Blue Choice</b>	\$20 copay per visit.
<b>Preferred Gold</b>	\$30 copay per visit.
<b>Blue PPO</b>	<b>Participating:</b> Covered at 80% subject to deductible. <b>Not Participating:</b> Covered at 70%, subject to deductible.
<b>BCBS Comprehensive</b>	Covered at 80%, subject to the deductible, less Medicare payment, if any.

## Notice to Plan Participants – Post-Mastectomy Benefits

On October 21, 1998, a new federal law entitled the "Women's Health and Cancer Rights Act" became effective. It requires group health plans sponsored by public and private employers to provide coverage for certain reconstructive surgery following a mastectomy. It's effective for group plans as of the first plan year beginning on or after October 21, 1998 (the date it was signed). There is no delayed effective date for collectively bargained plans. (The new law also applies to individual insurance products, for which the effective date is October 21, 1998.)

This law also requires that we (or the insurer carrier) send you this notice explaining the required benefits annually at each open enrollment. You may receive a notice from the insurance carrier as well as from us.

The specific requirements of the new law are that a plan which provides medical and surgical benefits for mastectomies must cover the following benefits for a member who undergoes a medically necessary mastectomy and who elects breast reconstruction after surgery:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to achieve a symmetrical appearance, and
- prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedemas.

This coverage will be provided as determined by the attending physician in consultation with the patient, and will be provided in a manner consistent with that applicable to other benefits (e.g., same annual deductibles and cost-sharing provisions that apply for other benefits).

If you have any questions about this plan's coverage of mastectomies and reconstructive surgery, please call the Member Services phone number listed in this booklet or on the back of your medical insurance ID card.