

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

Medicare Blue Choice HMO/POS and Preferred Gold HMO/POS 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

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

Contacting the Carrier

Medicare Blue Choice HMO/POS	Voice: (877) 883-9577 TTY: (585) 454-2845 Website: www.excellusbcbs.com
Preferred Gold HMO/POS	Voice: (800) 665-7924 TTY: (800) 252-2452 Website: www.mvphealthcare.com
Blue PPO	Voice: (877) 668-7636 TTY: (585) 454-2845 Website: www.excellusbcbs.com
BCBS Comprehensive	Voice: (877) 668-7636 TTY: (585) 454-2845 Website: www.excellusbcbs.com

Deductible Carry Over

Medicare Blue Choice HMO/POS	None.
Preferred Gold HMO/POS	None.
Blue PPO	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.
BCBS Comprehensive	None.

Deductible, Coinsurance, Annual Out of Pocket Maximum

Medicare Blue Choice HMO/POS	No annual deductible. \$3,400 out of pocket maximum (excludes prescription drugs). Coinsurance only applies to benefits noted.
Preferred Gold HMO/POS	No annual deductible. Coinsurance only applies to benefits noted. \$4,000 annual out of pocket maximum (excludes Rx).
Blue PPO	<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"> • 80% of covered services for <u>participating providers</u>, and • 70% of covered services for <u>non-participating providers</u>. <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>
BCBS Comprehensive	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)

Acupuncture

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

Allergy Tests & Injections

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

Ambulance

Medicare Blue Choice HMO/POS	\$50 copay.
Preferred Gold HMO/POS	\$75 copay per service when medical treatment is required during transport.
Blue PPO	Participating: \$50 copay Not Participating: \$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 HMO/POS	Unlimited days of hospital and physician care subject to the inpatient copay of \$250; (Limit of 2 copays per calendar year, or \$500).
Preferred Gold HMO/POS	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	Participating: 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. Not Participating: 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 HMO/POS	50% coinsurance per visit.
Preferred Gold HMO/POS	\$30 copay per visit.
Blue PPO	Participating: Covered at 80%, subject to deductible. Not Participating: Covered at 70%.
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment.

Chemotherapy

Medicare Blue Choice HMO/POS	\$20 copay per visit.
Preferred Gold HMO/POS	\$30 copay per visit (professionally administered)
Blue PPO	Participating: Covered at 80% subject to deductible. Not Participating: 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 HMO/POS	\$20 copay per visit, for manual manipulation of the spine only, according to Medicare guidelines.
Preferred Gold HMO/POS	\$20 copay per visit; for manual manipulation of the spine only.
Blue PPO	Participating: \$15 copay per visit Not Participating: 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 HMO/POS	Covered when related to an accidental injury to sound, natural teeth.
Preferred Gold HMO/POS	\$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)

Medicare Blue Choice HMO/POS	Covered at 80% with no deductible at network providers.
Preferred Gold HMO/POS	Covered at 80% with no deductible at network providers.
Blue PPO	<p>Participating: Standard equipment covered at 80%, subject to deductible.</p> <p>Not Participating: Standard equipment covered at 70%, subject to deductible.</p>
BCBS Comprehensive	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

Medicare Blue Choice HMO/POS	\$50 copay; waived if admitted within 23 hours.
Preferred Gold HMO/POS	\$65 copay medical emergencies; waived if admitted.
Blue PPO	<p>Participating: Emergency Room - \$50 per visit unless admitted within 24 hours.</p> <p>Not Participating: Emergency Room - \$50 per visit unless admitted within 24 hours.</p>
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any.

Eye Exams and Eyewear

Medicare Blue Choice HMO/POS	\$20 copay for routine eye exams, annually. \$60 material allowance for eyeglasses and contact lenses every year, including a 25% discount at participating providers. Eyeglasses covered in full after cataract surgery. Glaucoma screening covered in full.
Preferred Gold HMO/POS	<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>
Blue PPO	<p><u>Exams:</u></p> <p>Participating: \$15 copay for routine eye exams, once every 2 years. \$15 copay for eye exams associated with disease or injury.</p> <p>Not Participating: Covered at 70%, subject to deductible.</p> <p><u>Eyewear:</u></p> <p>Participating: \$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>Not Participating: \$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>
BCBS Comprehensive	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

Medicare Blue Choice HMO/POS	Silver&Fit® membership to participating fitness facilities for \$25 per year. There is a \$150 annual allowance to use at nonparticipant fitness facilities. Members who prefer to exercise at home, can choose 2 at home fitness kits per year (\$10 per kit) instead of the fitness facility.
Preferred Gold HMO/POS	Up to \$100 annually in HealthDollars to use toward health programs such as weight loss and smoking cessation. The SilverSneakers® 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. Members also receive 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.
Blue PPO	Not applicable.
BCBS Comprehensive	Not applicable.

Hearing Evaluations & Hearing Aids

Medicare Blue Choice HMO/POS	\$20 copay per visit for exam, and \$300 Hearing Aid allowance every 3 years.
Preferred Gold HMO/POS	Routine Hearing Evaluations covered with a \$30 copay. \$600 Hearing Aid allowance every 3 years.
Blue PPO	Participating: Routine evaluations and hearing aids not covered. Diagnostic exams covered at 80% subject to deductible. Not Participating: Routine evaluations and hearing aids not covered. Diagnostic exams covered at 70% subject to deductible.
BCBS Comprehensive	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 Health Care

Medicare Blue Choice HMO/POS	\$20 copay.
Preferred Gold HMO/POS	Covered in full.
Blue PPO	Participating: Covered at 80%, subject to \$50 deductible for unlimited days Not Participating: 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 HMO/POS	Covered in full by Medicare.
Preferred Gold HMO/POS	Covered in full by Medicare.
Blue PPO	Participating: Covered at 80% for unlimited visits Not Participating: 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 HMO/POS	Covered in full.
Preferred Gold HMO/POS	Covered in full.
Blue PPO	Participating: Covered at 80% subject to deductible. Not Participating: 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 HMO/POS	\$250 copay per admission (limit 2 copays per calendar year or \$500). Services include physician visits, anesthesia and surgery.
Preferred Gold HMO/POS	\$250 copay per admission (limit 3 copays per calendar year, or \$750). Services include physician visits, anesthesia and surgery.
Blue PPO	Participating: Covered at 80% subject to deductible Not Participating: 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

Medicare Blue Choice HMO/POS	Covered in full.
Preferred Gold HMO/POS	\$10 copay.
Blue PPO	Participating: Covered at 80% subject to deductible. Not Participating: 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 HMO/POS	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 HMO/POS	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	Participating: Covered at 80%, subject to deductible. Not Participating: Covered at 70%, subject to deductible.
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any.

Mental Health-Outpatient

Medicare Blue Choice HMO/POS	40% coinsurance. No maximum number of visits.
Preferred Gold HMO/POS	Covered with a \$30 copay. No maximum number of visits.
Blue PPO	Participating: Covered at 80%, subject to the deductible. Not Participating: Covered at 75%, subject to the deductible.
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any.

MRI, PET, CAT Scans

Medicare Blue Choice HMO/POS	
Preferred Gold HMO/POS	\$40 copay.
Blue PPO	Participating: Not Participating:
BCBS Comprehensive	Covered at 80% of the Schedule of Allowances, subject to the deductible, less Medicare payment, if any.

Occupational Therapy

Medicare Blue Choice HMO/POS	\$20 copay per visit.
Preferred Gold HMO/POS	\$30 copay per visit. The plan will pay a maximum of \$1,860 per calendar year for Occupational Therapy.
Blue PPO	Participating: 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. Not Participating: 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.
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any. No coverage for supplies.

Out of Area Coverage

Medicare Blue Choice HMO/POS	Coverage provided worldwide; urgent or emergent care is covered as if you are in-network. Routine care can be provided as an out of network benefit with no referrals. The out of network benefit covers routine care when you are outside the plan service area for up to six months. There is no deductible and you pay 20% coinsurance for covered services and the plan pays 80%. Up to a total of \$5,000 of out of network services are covered per year (i.e., you pay up to \$1,000, the plan pays up to \$4,000).
Preferred Gold HMO/POS	Worldwide Coverage for emergency care covered as in-network; Nationwide coverage for urgent care. In addition, the out of network benefit allows you to go anywhere in the U.S. for routine and elective services. Examples of covered services out of network include: Office visits, lab, 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). There is no deductible and you pay 30% coinsurance for covered services and the plan pays 70%. Up to a total of \$5,000 of out of network services are covered per year (i.e., you pay up to \$1,500, the plan pays up to \$3,500).
Blue PPO	Coverage provided worldwide.
BCBS Comprehensive	Coverage provided worldwide.

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

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

Physician Visits – In Office, Routine Preventive Services

Medicare Blue Choice HMO/POS	Periodic routine physicals, annual pelvic exam, Pap Smear, periodic routine mammograms and bone mass covered in full.
Preferred Gold HMO/POS	Periodic routine physicals, annual pelvic exam, Pap Smear, and periodic routine mammograms covered in full. Pneumococcal, Influenza and Hepatitis B vaccinations or immunizations covered in full.
Blue PPO	<p>Participating: Periodic routine physicals covered in full, 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>Not Participating: 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>
BCBS Comprehensive	<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>

Physical Therapy

Medicare Blue Choice HMO/POS	\$20 copay per visit.
Preferred Gold HMO/POS	\$30 copay per visit. The plan will pay a maximum of \$1,860 per calendar year for physical therapy and speech therapy, combined.
Blue PPO	<p>Participating: 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>Not Participating: 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>
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any.

Podiatry

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

Prescription Drugs Covered Under Medical Plan

Medicare Blue Choice HMO/POS
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 <u>30-day supply</u>	MAIL ORDER <u>90-day supply</u>
<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%.

Coverage Gap (donut hole)

When total drug costs paid by both you and Excellus BCBS reach \$2,930, you continue to pay the copays listed above. Coverage for the generic drugs will be provided by the Part D plan. Coverage for the brand name drugs will be provided by a wraparound group health plan.

Catastrophic Coverage: If your total copays during a calendar year exceed \$4,400, 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 \$2.60
- Brand Name – the greater of 5% of the drug's cost or \$6.50

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 HMO/POS

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 HMO/POS 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	\$30	\$60
<u>Tier 3:</u>		
Non-preferred drugs	\$60	\$120
<u>Tier 4:</u>		
Specialty drugs	\$60	\$120
<u>Tier 5:</u>		
Select generics	\$0	\$0

Diabetic supplies covered at 80%.

Coverage Gap (donut hole)

When total drug costs paid by both you and Preferred Gold HMO/POS reach \$2,930, you receive a 50% discount on your copay for Medicare contracted brand name medications until the catastrophic level is reached.

Catastrophic Coverage: If your total copays during a calendar year exceed \$4,700, 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 \$2.60
- Brand Name – the greater of 5% of the drug’s cost or \$6.50

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 HMO/POS	Covered in full when medically necessary and approved in advance by the Primary Care Physician.
Preferred Gold HMO/POS	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 HMO/POS	Covered at 80% with no deductible at network providers.
Preferred Gold HMO/POS	Covered at 80% with no deductible at network providers.
Blue PPO	Participating: Standard equipment covered at 80%, subject to the deductible, up to \$15,000 per member per calendar year Not Participating: 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 HMO/POS	Covered in full with no deductible.
Preferred Gold HMO/POS	Covered in full with no deductible at network providers.
Blue PPO	Participating: Covered at 80% subject to deductible. Not Participating: 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 HMO/POS	\$20 copay per visit.
Preferred Gold HMO/POS	Covered in full.
Blue PPO	Participating: Covered at 80% subject to deductible. Not Participating: 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

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

Skilled Nursing Facility

Medicare Blue Choice HMO/POS	Days 1-20: Covered in full. Days 21-100: Covered at 50%.
Preferred Gold HMO/POS	Days 1-20: Covered in full. Days 21-100: \$135 per day copay.
Blue PPO	<p>Participating: 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>Not Participating: 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>
BCBS Comprehensive	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

Medicare Blue Choice HMO/POS	\$20 copay per visit.
Preferred Gold HMO/POS	\$30 copay per visit. The plan will pay a maximum of \$1,860 per calendar year for physical therapy and speech therapy, combined.
Blue PPO	<p>Participating: 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>Not Participating: 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>
BCBS Comprehensive	Covered at 80%, subject to deductible, less Medicare payment, if any.

Travel Benefit

Medicare Blue Choice HMO/POS	Refer to Out of Area Coverage
Preferred Gold HMO/POS	Refer to Out of Area Coverage
Blue PPO	Refer to Out of Area Coverage
BCBS Comprehensive	Refer to Out of Area Coverage

Urgent Care

Medicare Blue Choice HMO/POS	\$50 copay for urgent care center.
Preferred Gold HMO/POS	\$30 copay for urgently needed services.
Blue PPO	<p>Participating: After Hours in physician's office - \$15 copay per visit. Freestanding Urgent Care Center - \$25 copay per visit.</p> <p>Not Participating: After Hours in physician's office – covered at 70%, subject to deductible. Freestanding Urgent Care Center - covered at 70%, subject to deductible.</p>
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any.

X-Ray-Diagnostic

Medicare Blue Choice HMO/POS	\$20 copay per visit.
Preferred Gold HMO/POS	\$30 copay per visit for x-rays. \$40 copay per visit for CT, PET, MRI.
Blue PPO	<p>Participating: Covered at 80% subject to deductible.</p> <p>Not Participating: Covered at 70%, subject to deductible.</p>
BCBS Comprehensive	Covered at 80%, subject to the deductible, less Medicare payment, if any.

Notice to Plan Participants-Women's Health and Cancer Rights Act of 1998

Under this Federal law, group health plans that provide medical and surgical benefits for mastectomies must provide coverage in connection with the mastectomy, in the manner determined by the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Further, the law prohibits:

- Penalizing or otherwise reducing or limiting the reimbursement of an attending physician for the required care;
- Providing any incentive (monetary or otherwise) to induce the attending physician to provide care that would be inconsistent with the law.

The above-described coverage required by the law may only be subject to the annual deductibles, copays, and coinsurance provisions that apply to similar benefits.