

type of care/plan features	Enhanced Plan Coverage*	Economy Plan 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 Diagnostic x-rays Diagnostic laboratory and pathology 	<ul style="list-style-type: none"> Not required Not required Not covered Coverage provided worldwide through the BlueCard® program. Qualified dependents and students are covered to age 26. Covered for same sex only <ul style="list-style-type: none"> \$15 copay \$15 copay None None None <ul style="list-style-type: none"> Covered in full Covered in full for 1 exam per year according to national guidelines Covered in full Covered in full Covered in full Covered in full \$15 copay \$15 copay for one routine exam per calendar year; \$100 eyewear allowance available per calendar year Preventive covered in full <ul style="list-style-type: none"> \$15 copay per visit \$15 copay. Precertification applies to MRI, PET and CAT scans. Covered in full 	<ul style="list-style-type: none"> Not required Not required Not covered Coverage provided worldwide through the BlueCard® program. Qualified dependents and students are covered to age 26. Covered for same sex only <ul style="list-style-type: none"> \$20 copay \$40 copay 20% \$250 individual/\$750 family \$750 individual/\$2250 family None <ul style="list-style-type: none"> Covered in full Covered in full for 1 exam per calendar year according to national guidelines Covered in full Covered in full Covered in full Covered in full Covered in full \$20 copay per visit with PCP, \$40 copay with specialist \$20 copay for one routine eye exam every year. \$60 eyewear allowance every year. Preventive covered in full <ul style="list-style-type: none"> \$20 copay per visit with PCP, \$40 copay per visits with specialist \$40 copay per visit. Precertification applies to MRI, PET and CAT scans. \$20 copay per visit

Comparison of benefits for Rochester City School District

12/2/2010

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<ul style="list-style-type: none"> Allergy tests Allergy injections Chemotherapy Radiation therapy Second Medical Opinion Sick Child Visits 	<ul style="list-style-type: none"> \$15 copay per visit \$15 copay per visit Covered in full Covered in full \$15 copay per visit \$0 to age 19 	<ul style="list-style-type: none"> \$20 copay per visit \$20 copay per visit \$40 copay per visit \$40 copay per visit \$40 copay per visit \$20 copay per visit with PCP, \$40 copay with specialist
<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 initial 10 visits, remainder of visits covered in full Hospital-Covered in full; Delivery-Covered in full with \$50 copayment in combination with prenatal and postpartum care. Covered in full 	<ul style="list-style-type: none"> \$5 copay for the first 10 visits, remainder of visits covered in full Covered at 80%, subject to the deductible Covered at 80%, 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/\$20/\$35 for retail and mail order. Retail 1 copay for 30 day supply or 3 copay for 90 day supply. Mail order 1 copay for 90 day supply 	<ul style="list-style-type: none"> \$10/\$30/\$50 for retail and mail order. Retail 1 copay for 30 day supply or 3 copay for 90 day supply. Mail order 2 copays for 90 day supply
<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 in full for unlimited days. Precertification applies. Covered in full Covered in full for up to 60 days per calendar year Covered in full Covered in full 	<ul style="list-style-type: none"> Covered at 80%, subject to the deductible. Precertification applies. Covered at 80%, subject to the deductible Covered at 80%, subject to the deductible for up to 60 days per calendar year. Precertification applies. Covered at 80%, subject to the deductible or \$100 copay 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"> \$50 copay per visit, unless admitted within 24 hours \$25 copay per visit \$15 copay 	<ul style="list-style-type: none"> \$50 copay per visit, unless admitted within 24 hours \$25 copay per visit \$50 copay
<p>Outpatient Hospital Benefits</p> <ul style="list-style-type: none"> Diagnostic x-rays 	<ul style="list-style-type: none"> \$15 copay per visit. Precertification applies to MRI, PET and CAT scans. 	<ul style="list-style-type: none"> \$40 copay per visit. Precertification applies to MRI, PET and CAT scans.

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<ul style="list-style-type: none"> • Diagnostic laboratory and pathology • Surgical care • Chemotherapy • Radiation therapy • Pulmonary Rehabilitation • Hemodialysis <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 • Hearing • Private duty nursing • Private Duty Nursing • Pre-admission testing 	<ul style="list-style-type: none"> • Covered in full • \$15 copay • Covered in full • Covered in full • \$15 copay per visit • Covered in full <ul style="list-style-type: none"> • Covered in full for unlimited days. Precertification applies. • \$15 copay. Services can be provided in an outpatient facility or in a provider office. • Covered in full for unlimited days. Precertification applies. • \$15 copay per visit <ul style="list-style-type: none"> • \$15 copay • Covered in full for up to 120 days per calendar year, 360 day lifetime max. Precertification applies. • Covered in full for unlimited visits. Precertification applies. • Covered in full for unlimited days • \$15 copay for up to a combined total of 45 visits per calendar year for physical, speech, occupational and respiratory therapy • Covered at 80%. Precertification applies. • Covered at 80% • \$15 copay per visit • Covered at 50% for up to 10 visits per calendar year • Covered same as similar service for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly • \$15 copay for diagnostic exam, no coverage for routine exams. Two hearing aids covered every 3 years for children to age 19. • Covered in full inpatient and at home • Covered in full 	<ul style="list-style-type: none"> • \$20 copay per visit • Covered at 80%, subject to the deductible • \$40 copay per visit • \$40 copay per visit • \$40 copay per visit • Covered at 80%, subject to the deductible <ul style="list-style-type: none"> • Covered at 80%, subject to the deductible. Precertification applies. • \$40 copay. Services can be provided in an outpatient facility or in a provider office. • Covered at 80%, subject to the deductible. Precertification applies. • \$40 copay <ul style="list-style-type: none"> • \$20 copay for up to a 30 day supply • Covered at 80%, subject to the deductible for up to 120 days per calendar year, 360 day lifetime max. Precertification applies. • \$20 per day, 40 visits per calendar year. Precertification applies. • Covered in full for unlimited days. • \$40 copay per visit for a combined total of 45 visits per calendar year for physical, speech, occupational and respiratory therapy • Covered at 50%, subject to the deductible. Precertification applies. • Covered at 50%, subject to the deductible • \$20 copay per visit • Covered at 50% for up to 10 visits per calendar year • Covered same as similar service for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly • \$20 copay for diagnostic exam, no coverage for routine exams. Two hearing aids covered every 3 years for children to age 19. • \$40 per day inpatient and at home • Covered in full