

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 <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 Allergy tests 	<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. <ul style="list-style-type: none"> \$15 copay, \$0 to age 19 \$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 Covered in full \$15 copay \$15 copay for one routine exam per year; \$100 eyewear allowance available per 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 \$15 copay per visit 	<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. <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 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 \$20 copay per visit

Comparison of benefits for Rochester City School District

11/2/2011

type of care/plan features	Enhanced Plan Coverage	Economy Plan Coverage
<ul style="list-style-type: none"> • Allergy injections • Chemotherapy • Radiation therapy • Second Medical Opinion • Sick Child Visits <p>Maternity Services</p> <ul style="list-style-type: none"> • Prenatal and postpartum care • Hospital care for mom (including delivery) • Newborn nursery care <p>Prescription Drug</p> <ul style="list-style-type: none"> • Short-term and maintenance drugs <p>Inpatient Hospital Benefits</p> <ul style="list-style-type: none"> • Hospital benefits • Physician visits in the hospital • Inpatient physical rehabilitation • Surgery • Anesthesia <p>Emergency Care</p> <ul style="list-style-type: none"> • Emergency room care • Freestanding urgent care center • Ambulance <p>Outpatient Hospital Benefits</p> <ul style="list-style-type: none"> • Diagnostic x-rays • Diagnostic laboratory and pathology 	<ul style="list-style-type: none"> • \$15 copay per visit • Covered in full • Covered in full • \$15 copay per visit • \$0 to age 19 <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/\$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"> • Covered in full for unlimited days. Precertification applies. • Covered in full • Covered in full for up to 60 days per year • Covered in full • Covered in full <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"> • \$15 copay per visit. Precertification applies to MRI, PET and CAT scans. • Covered in full 	<ul style="list-style-type: none"> • \$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 <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 <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 <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 year. Precertification applies. • Covered at 80%, subject to the deductible or \$100 copay • Covered at 80%, subject to the deductible <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"> • \$40 copay per visit. Precertification applies to MRI, PET and CAT scans. • \$20 copay per visit

type of care/plan features	Enhanced Plan Coverage	Economy Plan Coverage
<ul style="list-style-type: none"> • Surgical care • Chemotherapy • Pulmonary Rehabilitation • Hemodialysis • 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 • Hearing • Private duty nursing • Pre-admission testing 	<ul style="list-style-type: none"> • \$15 copay • Covered in full • \$15 copay per visit • Covered in full • 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 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 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 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"> • Covered at 80%, subject to the deductible • \$40 copay per visit • \$40 copay per visit • Covered at 80%, subject to the deductible • \$40 copay per visit <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 year, 360 day lifetime max. Precertification applies. • \$20 per day, 40 visits per year. Precertification applies. • Covered in full for unlimited days. • \$40 copay per visit for a combined total of 45 visits per 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 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