

Retiree + Enhanced EPO Over Age 65 Prepared for Rochester City School District

11/3/2011

Type of Care/Plan Benefits	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 	<ul style="list-style-type: none"> • Not required • Not required • Not covered • Coverage provided worldwide through the BlueCard® program • Qualified dependents are covered to age 19 Qualified students are covered to age 25 • Covered for same sex only • \$15 copay • \$15 copay • None • None • None • None
Type of Care/Plan Benefits	Coverage*
<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 • 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 	<ul style="list-style-type: none"> • Covered in full • Covered in full, limited to one exam per calendar year • Covered in full • Covered in full • Covered in full • \$10 copay • \$15 copay • \$15 copay for one routine exam per calendar year; \$100 eyewear allowance available per calendar year • \$15 copay • \$15 copay per visit, \$0 for children to age 19 for PCP • \$15 copay • Covered in full • \$15 copay per visit • \$15 copay per visit • Covered in full • Covered in full • \$15 copay per visit • \$0 to age 19 • \$5 copay for the first 10 visits then covered in full

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<ul style="list-style-type: none"> • 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 • 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 and supplies • External prosthetics and orthotics 	<ul style="list-style-type: none"> • 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 • 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"> • \$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 • Covered in full • \$15 copay per visit • Covered in full • Covered in full • \$15 copay per visit • Covered in full <ul style="list-style-type: none"> • Covered in full • \$15 copay per visits, services can be provided in an outpatient facility or in a provider office • Covered in full • \$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%, up to \$15,000 maximum per calendar year combined with external prosthetics • Covered at 80%, up to \$15,000 per calendar year combined with DME

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<ul style="list-style-type: none"> • Chiropractic • Acupuncture • Dental • Hearing • Private Duty Nursing • Pre-admission Testing 	<ul style="list-style-type: none"> • \$15 copay per visit • Covered at 50%, 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 exam, hearing aids covered up to \$600 for up to 2 hearing aids every 3 years for children to age 19 • Covered in full inpatient and at home • Covered in full