

Product Description - HMO		Single	Sub/Spouse	Sub/Child	Family
BC \$30/\$50 M ER 150 19/23 IP500 10/30/50 0G	435	\$ 451.24	\$ 1,037.73	\$ 1,118.99	\$ 1,177.33
BC \$30/50 M ER 150 19/23 IP750 Rx \$7 Generic	436	\$ 375.21	\$ 863.03	\$ 927.85	\$ 976.35



**Comparison of benefits for Geneva Chamber of Commerce -2010**

11/5/2009

type of care/plan features	Blue Choice \$30 Copay Option Coverage	Blue Choice \$30 Copay Option Coverage
<p><b>Plan features</b></p> <ul style="list-style-type: none"> <li>Primary Care Physician (PCP)</li> <li>Referrals</li> <li>Out of network benefits</li> <li>Out of area benefits</li> <li>Student/Dependent coverage</li> <li>Domestic partner</li> </ul> <p><b>Plan cost-sharing highlights</b></p> <ul style="list-style-type: none"> <li>Office visit copay (Primary Care Physician)</li> <li>Office visit copay (Specialist)</li> <li>Coinsurance</li> <li>Deductible</li> <li>Out of pocket maximum</li> <li>Lifetime maximum</li> </ul> <p><b>Preventive Health Care Services</b></p> <ul style="list-style-type: none"> <li>Well child visits</li> <li>Adult routine physical exams</li> <li>Adult immunizations</li> <li>Mammography</li> <li>Pap smear</li> <li>Routine GYN exam</li> <li>Prostate cancer screening</li> <li>Routine vision</li> <li>Colonoscopy</li> </ul> <p><b>Physician Office Services</b></p> <ul style="list-style-type: none"> <li>Diagnostic office visits</li> <li>Diagnostic x-rays</li> </ul>	<ul style="list-style-type: none"> <li>Required</li> <li>Required</li> <li>Not covered</li> <li>Emergency coverage provided worldwide through the BlueCard® program.</li> <li>Qualified dependents are covered to age 19. Qualified students are covered to age 23.</li> <li>Covered</li> <li>\$30 copay</li> <li>\$50 copay</li> <li>None</li> <li>None</li> <li>None</li> <li>None</li> <li>Covered in full</li> <li>\$30 copay per visit</li> <li>\$30 copay</li> <li>\$30 copay</li> <li>\$30 copay</li> <li>\$30 copay</li> <li>\$30 copay</li> <li>\$50 copay for one routine exam every 2 years; every year for children to age 19. Eyewear \$60 allowance every 2 years; every year for children to age 19.</li> <li>Preventive covered in full, diagnostic covered according to the surgical benefit</li> <li>\$30 copay per visit to your PCP; \$50 copay per visit to a specialist</li> <li>\$50 copay per visit</li> </ul>	<ul style="list-style-type: none"> <li>Required</li> <li>Required</li> <li>Not covered</li> <li>Emergency coverage provided worldwide through the BlueCard® program.</li> <li>Qualified dependents are covered to age 19. Qualified students are covered to age 23.</li> <li>Covered</li> <li>\$30 copay</li> <li>\$50 copay</li> <li>None</li> <li>None</li> <li>None</li> <li>None</li> <li>Covered in full</li> <li>\$30 copay per visit</li> <li>\$30 copay</li> <li>\$30 copay</li> <li>\$30 copay</li> <li>\$30 copay</li> <li>\$30 copay</li> <li>\$30 copay</li> <li>Not covered</li> <li>Preventive covered in full, diagnostic covered according to the surgical benefit</li> <li>\$30 copay per visit to your PCP; \$50 copay per visit to a specialist</li> <li>\$50 copay per visit</li> </ul>



## Comparison of benefits for Geneva Chamber of Commerce -2010

11/5/2009

type of care/plan features	Blue Choice \$30 Copay Option  Coverage	Blue Choice \$30 Copay Option  Coverage
<ul style="list-style-type: none"> <li>Diagnostic laboratory and pathology</li> <li>Allergy tests</li> <li>Allergy injections</li> <li>Chemotherapy</li> <li>Radiation therapy</li> </ul>	<ul style="list-style-type: none"> <li>\$30 copay per visit</li> <li>\$30 copay per visit to your PCP; \$50 copay per visit to a specialist</li> <li>\$30 copay per visit to your PCP; \$50 copay per visit to a specialist</li> <li>\$30 copay for IV/injectable chemotherapy, in addition to a \$30 copay for the office visit</li> <li>\$30 copay per visit</li> </ul>	<ul style="list-style-type: none"> <li>\$30 copay per visit</li> <li>\$30 copay per visit to your PCP; \$50 copay per visit to a specialist</li> <li>\$30 copay per visit to your PCP; \$50 copay per visit to a specialist</li> <li>\$30 copay for IV/injectable chemotherapy, in addition to a \$30 copay for the office visit</li> <li>\$30 copay per visit</li> </ul>
<p><b>Maternity Services</b></p> <ul style="list-style-type: none"> <li>Prenatal and postpartum care</li> <li>Hospital care for mom (including delivery)</li> <li>Newborn nursery care</li> </ul>	<ul style="list-style-type: none"> <li>\$10 copay per visit for the first 10 visits; remainder of visits covered in full</li> <li>Facility: Subject to \$500 copay per admission. Physician: Subject to 20% coinsurance or \$300 copay, whichever is less</li> <li>Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>\$10 copay per visit for the first 10 visits; remainder of visits covered in full</li> <li>Facility: Subject to \$500 copay per admission. Physician: Subject to 20% coinsurance or \$300 copay, whichever is less</li> <li>Covered in full</li> </ul>
<p><b>Prescription Drug</b></p> <ul style="list-style-type: none"> <li>Short-term and maintenance drugs are covered up to a 30-day supply at participating retail pharmacies; 90-day supply (subject to two copays per 90-day supply) is available through PrimeMail® mail order pharmacy. Contraceptives included.</li> </ul>	<ul style="list-style-type: none"> <li>\$10/\$30/\$50</li> </ul>	<ul style="list-style-type: none"> <li>\$7 copay for generics only</li> </ul>
<p><b>Inpatient Hospital Benefits</b></p> <ul style="list-style-type: none"> <li>Hospital benefits</li> <li>Physician visits in the hospital</li> <li>Inpatient physical rehabilitation</li> <li>Surgery</li> <li>Anesthesia</li> </ul>	<ul style="list-style-type: none"> <li>Subject to \$500 copay per admission for unlimited days</li> <li>Covered in full</li> <li>Subject to \$500 copay per admission for up to 60 days per calendar year</li> <li>Facility: Subject to \$500 copay; Physician: Subject to 20% coinsurance or \$300 copay, whichever is less</li> <li>Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>Subject to \$500 copay per admission for unlimited days</li> <li>Covered in full</li> <li>Not covered</li> <li>Facility: Subject to \$500 copay; Physician: Subject to 20% coinsurance or \$300 copay, whichever is less</li> <li>Covered in full</li> </ul>
<p><b>Emergency Care</b></p> <ul style="list-style-type: none"> <li>Emergency room care</li> <li>Freestanding urgent care center</li> <li>Ambulance</li> </ul>	<ul style="list-style-type: none"> <li>\$150 copay per visit, unless admitted within 24 hours</li> <li>\$50 copay per visit</li> <li>\$100 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$150 copay per visit, unless admitted within 24 hours</li> <li>\$50 copay per visit</li> <li>\$100 copay</li> </ul>
<p><b>Outpatient Hospital Benefits</b></p>		



## Comparison of benefits for Geneva Chamber of Commerce -2010

11/5/2009

type of care/plan features	Blue Choice \$30 Copay Option Coverage	Blue Choice \$30 Copay Option Coverage
<ul style="list-style-type: none"> <li>. Diagnostic x-rays</li> <li>. Diagnostic laboratory and pathology</li> <li>. Surgical care</li> <li>. Chemotherapy</li>   <li>. Radiation therapy</li>   <li><b>Mental Health and Chemical Dependence</b></li>   <li>. Inpatient mental health care</li> <li>. Outpatient mental health care</li> <li>. Inpatient chemical dependence</li>   <li>. Outpatient chemical dependence</li>   <li><b>Other Services</b></li>   <li>. Diabetic insulin and supplies</li> <li>. Skilled nursing facility</li>   <li>. Home care</li> <li>. Hospice</li>   <li>. Outpatient therapy</li>   <li>. Durable medical equipment</li> <li>. External prosthetics</li> <li>. Chiropractic</li> <li>. Acupuncture</li> <li>. Dental</li>   <li>. Hearing</li> </ul>	<ul style="list-style-type: none"> <li>. \$50 copay per visit</li> <li>. \$30 copay per visit</li> <li>. Facility: \$150 copay; Physician: \$50 copay</li> <li>. \$30 copay for IV/injectable chemotherapy, in addition to a \$30 copay for the office visit</li> <li>. \$30 copay per visit</li>   <li>. Subject to \$500 copay per admission for up to 30 days per calendar year</li> <li>. \$50 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider's office.</li> <li>. Subject to \$500 copay per admission per visit for up to 7 days for detoxification and 30 days for rehabilitation per calendar year</li> <li>. \$30 copay per visit for up to 60 visits per calendar year</li>   <li>. \$25 copay for up to a 30 day supply</li> <li>. Subject to \$500 copay per admission for up to 45 days per admission, 360 days per lifetime</li> <li>. \$30 copay per visit for up to 40 visits per calendar year</li> <li>. Subject to \$500 copay per admission for up to 210 days per lifetime</li> <li>. \$50 copay per visit for up to a combined total of 30 visits per calendar year for physical, speech, occupational and respiratory therapy</li> <li>. Covered at 50% up to \$5,000 per calendar year</li> <li>. Covered at 50% up to \$15,000 per calendar year</li> <li>. \$50 copay per visit</li> <li>. Not covered</li> <li>. Covered same as similar services under benefit plan for accidental injury to sound natural teeth.</li> <li>. \$50 copay for diagnostic and routine hearing exams. Hearing aids not covered.</li> </ul>	<ul style="list-style-type: none"> <li>. \$50 copay per visit</li> <li>. \$30 copay per visit</li> <li>. Facility: \$150 copay; Physician: \$50 copay</li> <li>. \$30 copay for IV/injectable chemotherapy, in addition to a \$30 copay for the office visit</li> <li>. \$30 copay per visit</li>   <li>. Subject to \$500 copay per admission for up to 30 days per calendar year</li> <li>. \$50 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider's office.</li> <li>. Not covered</li>   <li>. \$30 copay per visit for up to 60 visits per calendar year</li>   <li>. \$25 copay for up to a 30 day supply</li> <li>. Subject to \$500 copay per admission for up to 45 days per admission, 360 days per lifetime</li> <li>. \$30 copay per visit for up to 40 visits per calendar year</li> <li>. Not covered</li>   <li>. \$50 copay per visit for up to a combined total of 30 visits per calendar year for physical, speech, occupational and respiratory therapy</li> <li>. Not covered</li> <li>. Not covered</li> <li>. \$50 copay per visit</li> <li>. Not covered</li> <li>. Covered same as similar services under benefit plan for accidental injury to sound natural teeth.</li> <li>. \$50 copay for diagnostic and routine hearing exams. Hearing aids not covered.</li> </ul>