



Comparison of benefits for Geneva Chamber of Commerce -2010

11/5/2009

type of care/plan features	SimplyBlue Copay Option		SimplyBlue Copay Option		SimplyBlue High Deductible Health Plan (HDHP) Option	
	In-Network	Out Of Network	In-Network	Out Of Network	In-Network	Out Of Network
Plan features						
<ul style="list-style-type: none"> Primary Care Physician (PCP) Referrals Out of network benefits Out of area benefits Student/Dependent coverage 	<ul style="list-style-type: none"> Not required Not required Covered at 60%, subject to the deductible Coverage provided worldwide through the BlueCard® program. Qualified dependents are covered to age 19. Qualified students are covered to age 23. 	<ul style="list-style-type: none"> Not required Not required Covered at 60%, subject to the deductible Coverage provided worldwide through the BlueCard® program. Qualified dependents are covered to age 19. Qualified students are covered to age 23; Qualified dependents and students are covered to age 26. 	<ul style="list-style-type: none"> Not required Not required Covered at 60%, subject to the deductible Coverage provided worldwide through the BlueCard® program. Qualified dependents are covered to age 19. Qualified students are covered to age 23; Qualified dependents and students are covered to age 26. 	<ul style="list-style-type: none"> Not required Not required Covered at 60%, subject to the deductible Coverage provided worldwide through the BlueCard® program. Qualified dependents are covered to age 19. Qualified students are covered to age 23; Qualified dependents and students are covered to age 26. 	<ul style="list-style-type: none"> Not required Not required Covered at 60%, subject to the deductible Coverage provided worldwide through the BlueCard® program. Qualified dependents are covered to age 19. Qualified students are covered to age 23; Qualified dependents and students are covered to age 26. 	<ul style="list-style-type: none"> Not required Not required Covered at 60%, subject to the deductible Coverage provided worldwide through the BlueCard® program. Qualified dependents are covered to age 19. Qualified students are covered to age 23; Qualified dependents and students are covered to age 26.
<ul style="list-style-type: none"> Domestic partner 	<ul style="list-style-type: none"> Covered 	<ul style="list-style-type: none"> Covered 	<ul style="list-style-type: none"> Covered 	<ul style="list-style-type: none"> Covered 	<ul style="list-style-type: none"> Covered 	<ul style="list-style-type: none"> Covered
Plan cost-sharing highlights						
<ul style="list-style-type: none"> Office visit copay (Primary Care Physician) Office visit copay (Specialist) 	<ul style="list-style-type: none"> Adults and Children: \$30 Copay per visit 	<ul style="list-style-type: none"> Adults and Children: \$30 Copay per visit 	<ul style="list-style-type: none"> Adults and Children: \$30 Copay per visit 	<ul style="list-style-type: none"> Adults and Children: \$30 Copay per visit 	<ul style="list-style-type: none"> Adults and Children: \$30 Copay per visit 	<ul style="list-style-type: none"> Adults and Children: \$30 Copay per visit
<ul style="list-style-type: none"> Coinsurance Deductible Out of pocket maximum Lifetime maximum 	<ul style="list-style-type: none"> In-network: None; Out-of-network: 40% In-network: None Out of Network \$2,000 individual /\$6,000 family Combined in and out-of-network: \$6,000 individual/\$18,000 family None 	<ul style="list-style-type: none"> In-network: None; Out-of-network: 40% In-network: None Out of Network \$2,000 individual /\$6,000 family Combined in and out-of-network: \$6,000 individual/\$18,000 family None 	<ul style="list-style-type: none"> In-network: None; Out-of-network: 40% In-network: None Out of Network \$2,000 individual /\$6,000 family Combined in and out-of-network: \$6,000 individual/\$18,000 family None 	<ul style="list-style-type: none"> In-network: None; Out-of-network: 40% In-network: None Out of Network \$2,000 individual /\$6,000 family Combined in and out-of-network: \$6,000 individual/\$18,000 family None 	<ul style="list-style-type: none"> In-network: None; Out-of-network: 40% In-network: None Out of Network \$2,000 individual /\$6,000 family Combined in and out-of-network: \$6,000 individual/\$18,000 family None 	<ul style="list-style-type: none"> In-network: None; Out-of-network: 40% In-network: None Out of Network \$2,000 individual /\$6,000 family Combined in and out-of-network: \$6,000 individual/\$18,000 family None
Preventive Health Care Services						
<ul style="list-style-type: none"> Well child visits Adult routine physical exams 	<ul style="list-style-type: none"> Covered in full Covered in full for 1 exam per calendar year 	<ul style="list-style-type: none"> Covered in full Covered at 60%, subject to the deductible for one routine exam per calendar year 	<ul style="list-style-type: none"> Covered in full Covered in full for 1 exam per calendar year 	<ul style="list-style-type: none"> Covered in full Covered at 60%, subject to the deductible for one routine exam per calendar year 	<ul style="list-style-type: none"> Covered in full Covered in full for 1 exam per calendar year 	<ul style="list-style-type: none"> Covered in full Covered at 60%, subject to the deductible for one routine exam per calendar year
<ul style="list-style-type: none"> Adult immunizations 	<ul style="list-style-type: none"> Covered in full 	<ul style="list-style-type: none"> Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> Covered in full 	<ul style="list-style-type: none"> Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> Covered in full 	<ul style="list-style-type: none"> Covered at 60%, subject to the deductible
<ul style="list-style-type: none"> Mammography 	<ul style="list-style-type: none"> Covered in full 	<ul style="list-style-type: none"> Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> Covered in full 	<ul style="list-style-type: none"> Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> Covered in full 	<ul style="list-style-type: none"> Covered at 60%, subject to the deductible



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	In-Network	Out Of Network	In-Network	Out Of Network	In-Network	Out Of Network
• Pap smear	• Covered in full	• Covered at 60%, subject to the deductible	• Covered in full	• Covered at 60%, subject to the deductible	• Covered in full	• Covered at 60%, subject to the deductible
• Routine GYN exam	• Covered in full	• Covered at 60%, subject to the deductible	• Covered in full	• Covered at 60%, subject to the deductible	• Covered in full	• Covered at 60%, subject to the deductible
• Prostate cancer screening	• Covered in full	• Covered at 60%, subject to the deductible	• Covered in full	• Covered at 60%, subject to the deductible	• Covered in full	• Covered at 60%, subject to the deductible
• Routine vision	• \$50 copay for one routine exam every year; \$60 eyewear allowance available per calendar year	• Covered at 60%, subject to the deductible for one routine exam per calendar year. \$60 eyewear allowance available per calendar year	• \$50 copay for one routine exam every year; \$60 eyewear allowance available per calendar year	• Covered at 60%, subject to the deductible for one routine exam per calendar year. \$60 eyewear allowance available per calendar year	• Covered at 80%, subject to the deductible for one routine exam per calendar year	• Covered at 60%, subject to the deductible for one routine exam per calendar year
• Colonoscopy	• Preventive covered in full, diagnostic covered according to the surgical benefit	• Covered at 60%, subject to the deductible	• Preventive covered in full, diagnostic covered according to the surgical benefit	• Covered at 60%, subject to the deductible	• Preventive covered in full, diagnostic covered according to the surgical benefit	• Covered at 60%, subject to the deductible
Physician Office Services						
• Diagnostic office visits	• \$30 copay per visit to your PCP; \$50 copay per visit to a specialist	• Covered at 60%, subject to the deductible	• \$30 copay per visit to your PCP; \$50 copay per visit to a specialist	• Covered at 60%, subject to the deductible	• Covered at 80%, subject to the deductible	• Covered at 60%, subject to the deductible
• Diagnostic x-rays	• \$75 copay per visit	• Covered at 60%, subject to the deductible	• \$75 copay per visit	• Covered at 60%, subject to the deductible	• Covered at 80%, subject to the deductible	• Covered at 60%, subject to the deductible
• Diagnostic laboratory and pathology	• \$50 copay per visit to a specialist.	• Covered at 60%, subject to the deductible	• \$50 copay per visit to a specialist.	• Covered at 60%, subject to the deductible	• Covered at 80%, subject to the deductible	• Covered at 60%, subject to the deductible
• Allergy tests	• \$30 copay per visit to your PCP. \$50 copay per visit to a specialist.	• Covered at 60%, subject to the deductible	• \$30 copay per visit to your PCP. \$50 copay per visit to a specialist.	• Covered at 60%, subject to the deductible	• Covered at 80%, subject to the deductible	• Covered at 60%, subject to the deductible
• Allergy injections	• \$30 copay per visit to your PCP; \$50 copay per visit to a specialist	• Covered at 60%, subject to the deductible	• \$30 copay per visit to your PCP; \$50 copay per visit to a specialist	• Covered at 60%, subject to the deductible	• Covered at 80%, subject to the deductible	• Covered at 60%, subject to the deductible
• Chemotherapy	• \$30 copay for IV/injectable chemotherapy, in addition to a \$30 copay for the office visit	• Covered at 60%, subject to the deductible	• \$30 copay for IV/injectable chemotherapy, in addition to a \$30 copay for the office visit	• Covered at 60%, subject to the deductible	• Covered at 80%, subject to the deductible	• Covered at 60%, subject to the deductible



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<ul style="list-style-type: none"> • Radiation therapy 	<ul style="list-style-type: none"> • \$50 copay per visit 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> • \$50 copay per visit 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible
Maternity Services						
<ul style="list-style-type: none"> • Prenatal and postpartum care 	<ul style="list-style-type: none"> • Covered in full 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> • Covered in full 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible
<ul style="list-style-type: none"> • Hospital care for mom (including delivery) 	<ul style="list-style-type: none"> • Covered in full 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> • Covered in full 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible
<ul style="list-style-type: none"> • Newborn nursery care 	<ul style="list-style-type: none"> • Covered in full 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> • Covered in full 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible
Prescription Drug						
<ul style="list-style-type: none"> • Short-term and maintenance drugs 	<ul style="list-style-type: none"> • \$5/\$35/\$70; \$0 copay for generics for children to age 19. 	<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • \$7 copay for generics only; \$0 copay for generics for children to age 19. 	<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • \$5/\$35/\$70; \$0 copay for generics for children to age 19, subject to deductible. 	<ul style="list-style-type: none"> • Not covered
Inpatient Hospital Benefits						
<ul style="list-style-type: none"> • Hospital benefits 	<ul style="list-style-type: none"> • Subject to \$500 copay per day for up to 4 days per admission and unlimited days 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible. 	<ul style="list-style-type: none"> • Subject to \$500 copay per day for up to 4 days per admission for unlimited days 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible. 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible. 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible.
<ul style="list-style-type: none"> • Physician visits in the hospital 	<ul style="list-style-type: none"> • Covered in full 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> • Covered in full 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible
<ul style="list-style-type: none"> • Inpatient physical rehabilitation 	<ul style="list-style-type: none"> • Subject to \$500 copay per day for up to 4 days per admission and 60 days per calendar year. 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible for up to 60 days per calendar year 	<ul style="list-style-type: none"> • Subject to \$500 copay per day for up to 4 days per admission and 60 days per calendar year. 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible for up to 60 days per calendar year 	<ul style="list-style-type: none"> • Subject to the deductible for up to 60 days per calendar year 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible for up to 60 days per calendar year
<ul style="list-style-type: none"> • Surgery 	<ul style="list-style-type: none"> • \$250 Copay 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> • \$250 Copay 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 60%, subject to the deductible
<ul style="list-style-type: none"> • Anesthesia 	<ul style="list-style-type: none"> • Covered in full 	<ul style="list-style-type: none"> • Covered in full 	<ul style="list-style-type: none"> • Covered in full 	<ul style="list-style-type: none"> • Covered in full 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible
Emergency Care						



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<ul style="list-style-type: none"> Emergency room care Freestanding urgent care center Ambulance 	<ul style="list-style-type: none"> \$250 copay per visit, unless admitted within 24 hours \$75 copay per visit \$250 copay 	<ul style="list-style-type: none"> \$250 copay per visit, unless admitted within 24 hours Covered at 60%, subject to the deductible \$250 copay 	<ul style="list-style-type: none"> \$250 copay per visit, unless admitted within 24 hours \$75 copay per visit \$250 copay 	<ul style="list-style-type: none"> \$250 copay per visit, unless admitted within 24 hours Covered at 60%, subject to the deductible \$250 copay 	<ul style="list-style-type: none"> Covered at 80%, subject to the deductible Covered at 80%, subject to the deductible Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> Covered at 80%, subject to the deductible Covered at 60%, subject to the deductible Covered at 80%, subject to the deductible
Outpatient Hospital Benefits						
<ul style="list-style-type: none"> Diagnostic x-rays Diagnostic laboratory and pathology Surgical care Chemotherapy Radiation therapy 	<ul style="list-style-type: none"> \$75 copay per visit \$50 copay per visit to a specialist. \$250 copay \$30 copay for IV/injectable chemotherapy, in addition to a \$30 copay for the office visit \$50 copay per visit 	<ul style="list-style-type: none"> Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> \$75 copay per visit \$50 copay per visit to a specialist. \$250 copay \$30 copay for IV/injectable chemotherapy, in addition to a \$30 copay for the office visit \$50 copay per visit 	<ul style="list-style-type: none"> Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible 	<ul style="list-style-type: none"> Covered at 80%, subject to the deductible Covered at 80%, subject to the deductible Covered at 80%, subject to the deductible Covered at 80%, subject to the deductible Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible Covered at 60%, subject to the deductible
Mental Health and Chemical Dependence						
<ul style="list-style-type: none"> Inpatient mental health care Outpatient mental health care 	<ul style="list-style-type: none"> Subject to \$500 copay per day for up to 4 days per admission for unlimited days \$50 copay. Services can be provided in an outpatient facility or in a provider's office. 	<ul style="list-style-type: none"> Covered at 60%, subject to the deductible. Covered at 60%, subject to the deductible. Services can be provided in an outpatient facility or in a provider's office. 	<ul style="list-style-type: none"> Subject to \$500 copay per day for up to 4 days per admission for unlimited days \$50 copay. Services can be provided in an outpatient facility or in a provider's office. 	<ul style="list-style-type: none"> Covered at 60%, subject to the deductible. Covered at 60%, subject to the deductible. Services can be provided in an outpatient facility or in a provider's office. 	<ul style="list-style-type: none"> Covered at 80%, subject to the deductible. Covered at 80%, subject to the deductible. Services can be provided in an outpatient facility or in a provider's office. 	<ul style="list-style-type: none"> Covered at 60%, subject to the deductible. Covered at 60%, subject to the deductible. Services can be provided in an outpatient facility or in a provider's office.



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• Inpatient chemical dependence	• Subject to \$500 copay per day for up to 4 days per admission for unlimited days	• Covered at 60%, subject to the deductible.	• Subject to \$500 copay per day for up to 4 days per admission for unlimited days	• Covered at 60%, subject to the deductible.	• Covered at 80%, subject to the deductible.	• Covered at 60%, subject to the deductible.
• Outpatient chemical dependence	• \$50 copay per visit	• Covered at 60%, subject to the deductible	• \$50 copay per visit	• Covered at 60%, subject to the deductible	• Covered at 80%, subject to the deductible	• Covered at 60%, subject to the deductible
Other Services						
• Diabetic insulin and supplies	• \$30 copay for up to a 30 day supply	• Covered at 60%, subject to the deductible for up to a 30 day supply	• \$30 copay for up to a 30 day supply	• Covered at 60%, subject to the deductible for up to a 30 day supply	• Covered at 80%, subject to the deductible for up to a 30 day supply	• Covered at 60%, subject to the deductible for up to a 30 day supply
• Skilled nursing facility	• Subject to \$500 copay per day for up to 4 days per admission and up to 45 days per calendar year	• Covered at 60%, subject to the deductible for up to 45 days per calendar year	• Subject to \$500 copay per day for up to 4 days per admission and up to 45 days per calendar year	• Covered at 60%, subject to the deductible for up to 45 days per calendar year	• Covered at 80%, subject to the deductible for up to 45 days per calendar year	• Covered at 60%, subject to the deductible for up to 45 days per calendar year
• Home care	• Covered in full for up to 40 visits per calendar year	• Covered at 60%, subject to a \$50 deductible for up to 40 visits per calendar year.	• Covered in full for up to 40 visits per calendar year	• Covered at 60%, subject to a \$50 deductible for up to 40 visits per calendar year.	• Covered at 80%, subject to the deductible for up to 40 visits per calendar year.	• Covered at 60%, subject to the deductible for up to 40 visits per calendar year.
• Hospice	• Covered in full for unlimited visits	• Covered at 60%, subject to the deductible for unlimited visits per calendar year	• Covered in full for unlimited visits	• Covered at 60%, subject to the deductible for unlimited visits per calendar year	• Covered at 80%, subject to the deductible for unlimited visits per calendar year	• Covered at 60%, subject to the deductible for unlimited visits per calendar year
• Outpatient therapy	• \$50 copay for up to a combined total of 45 visits per calendar year for physical, speech and occupational therapy	• Covered at 60%, subject to the deductible for a combined total of 45 visits per calendar year for physical, speech, and occupational therapy	• \$50 copay for up to a combined total of 45 visits per calendar year for physical, speech and occupational therapy	• Covered at 60%, subject to the deductible for a combined total of 45 visits per calendar year for physical, speech, and occupational therapy	• Covered at 80%, subject to the deductible for a combined total of 45 visits per calendar year for physical, speech and occupational therapy	• Covered at 60%, subject to the deductible for a combined total of 45 visits per calendar year for physical, speech, and occupational therapy
• Durable medical equipment	• Covered at 50% for up to \$15,000 per calendar year combined with external prosthetics and orthotics	• Not covered	• Covered at 50% for up to \$15,000 per calendar year combined with external prosthetics and orthotics	• Not covered	• Covered at 80% subject to the deductible for up to \$15,000 per calendar year combined with external prosthetics and orthotics	• Covered at 60% subject to the deductible for up to \$15,000 per calendar year combined with external prosthetics and orthotics



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• External prosthetics	• Covered at 50% for up to \$15,000 per calendar year combined with DME and orthotics	• Not covered	• Covered at 50% for up to \$15,000 per calendar year combined with DME and orthotics	• Not covered	• Covered at 80%, subject to the deductible for up to \$15,000 per calendar year combined with DME and orthotics	• Covered at 60% subject to the deductible for up to \$15,000 per calendar year combined with DME and orthotics
• Chiropractic	• \$50 copay per visit	• Covered at 60%, subject to the deductible	• \$50 copay per visit	• Covered at 60%, subject to the deductible	• Covered at 80%, subject to the deductible	• Covered at 60%, subject to the deductible
• Acupuncture	• \$50 copay for up to 10 visits per calendar year	• Covered at 60%, subject to the deductible, for up to 10 visits per calendar year	• \$50 copay for up to 10 visits per calendar year	• Covered at 60%, subject to the deductible, for up to 10 visits per calendar year	• Covered at 80%, subject to the deductible, for up to 10 visits per calendar year	• Covered at 60%, subject to the deductible, for up to 10 visits per calendar year
• Dental	• \$50 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	• Covered at 60%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	• \$50 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	• Covered at 60%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	• Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly	• Covered at 60%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
• Hearing	• \$50 copay for one routine hearing exam per calendar year. Hearing aids covered up to \$600 every 3 years for children to age 19.	• Covered at 60%, subject to the deductible, for one routine hearing exam per calendar year. Hearing aids covered up to \$600 every 3 years for children to age 19.	• \$50 copay for one routine hearing exam per calendar year. Hearing aids covered up to \$600 every 3 years for children to age 19.	• Covered at 60%, subject to the deductible, for one routine hearing exam per calendar year. Hearing aids covered up to \$600 every 3 years for children to age 19.	• Covered at 80%, subject to the deductible, for one routine hearing exam per calendar year.	• Covered at 60%, subject to the deductible, for one routine hearing exam per calendar year.

Geneva Chamber 7494-011

Rating Region - ROC

The product(s) you have requested is/are called Simply Blue

Product Description HB Copay Options	Pkg #	Proposed Rates			
		Single	Sub/Spouse	Sub/Child	Family
SB \$30/\$50 M 19/23 ER 250 IP500/4 day Rx 5/35/70 0GK	170	\$ 312.24	\$ 761.85	\$ 633.38	\$ 806.98
SB \$30/\$50 M 19/23 ER 250 IP500/4 day Rx \$7 Generic 0GK	174	\$ 260.52	\$ 633.43	\$ 538.89	\$ 677.67
SB \$30/\$50 M 26/26 ER 250 IP500/4 day Rx \$7 Generic 0GK	171	\$ 260.52	\$ 633.43	\$ 548.44	\$ 689.84

Product Description SB HDHP		Single	Sub/Spouse	Sub/Child	Family
SB HDHP 1300/2600 19/23 Rx 5/35/70	173	\$ 189.67	\$ 462.81	\$ 386.82	\$ 492.83
SB HDHP 1300/2600 26/26 Rx 5/35/70	172	\$ 189.67	\$ 462.81	\$ 394.25	\$ 502.30