

Product Description - HMO	Pkg #	Proposed Rates			
		Single	Sub/Spouse	Sub/Child	Family
BC \$30/\$50 M ER 150 19/23 IP500 10/30/50 0G	436	\$ 392.38	\$ 902.39	\$ 973.05	\$ 1,023.78
BC \$30/50 M ER 150 19/23 IP750 Rx \$7 Generic	435	\$ 326.27	\$ 750.47	\$ 806.84	\$ 849.00



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>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 	<ul style="list-style-type: none"> Required Required Not covered Emergency coverage provided worldwide through the BlueCard® program. Qualified dependents are covered to age 19. Qualified students are covered to age 23. Covered \$30 copay \$50 copay None None None None Covered in full \$30 copay per visit \$30 copay \$30 copay \$30 copay \$30 copay \$30 copay \$30 copay \$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. Preventive covered in full, diagnostic covered according to the surgical benefit \$30 copay per visit to your PCP; \$50 copay per visit to a specialist \$50 copay per visit 	<ul style="list-style-type: none"> Required Required Not covered Emergency coverage provided worldwide through the BlueCard® program. Qualified dependents are covered to age 19. Qualified students are covered to age 23. Covered \$30 copay \$50 copay None None None None Covered in full \$30 copay per visit \$30 copay \$30 copay \$30 copay \$30 copay \$30 copay \$30 copay Not covered Preventive covered in full, diagnostic covered according to the surgical benefit \$30 copay per visit to your PCP; \$50 copay per visit to a specialist \$50 copay per visit



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"> Diagnostic laboratory and pathology Allergy tests Allergy injections Chemotherapy Radiation therapy 	<ul style="list-style-type: none"> \$30 copay per visit \$30 copay per visit to your PCP; \$50 copay per visit to a specialist \$30 copay per visit to your PCP; \$50 copay per visit to a specialist \$30 copay for IV/injectable chemotherapy, in addition to a \$30 copay for the office visit \$30 copay per visit 	<ul style="list-style-type: none"> \$30 copay per visit \$30 copay per visit to your PCP; \$50 copay per visit to a specialist \$30 copay per visit to your PCP; \$50 copay per visit to a specialist \$30 copay for IV/injectable chemotherapy, in addition to a \$30 copay for the office visit \$30 copay per visit
<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"> \$10 copay per visit for the first 10 visits; remainder of visits covered in full Facility: Subject to \$500 copay per admission. Physician: Subject to 20% coinsurance or \$300 copay, whichever is less Covered in full 	<ul style="list-style-type: none"> \$10 copay per visit for the first 10 visits; remainder of visits covered in full Facility: Subject to \$500 copay per admission. Physician: Subject to 20% coinsurance or \$300 copay, whichever is less Covered in full
<p>Prescription Drug</p> <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> \$10/\$30/\$50 	<ul style="list-style-type: none"> \$7 copay for generics only
<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"> Subject to \$500 copay per admission for unlimited days Covered in full Subject to \$500 copay per admission for up to 60 days per calendar year Facility: Subject to \$500 copay; Physician: Subject to 20% coinsurance or \$300 copay, whichever is less Covered in full 	<ul style="list-style-type: none"> Subject to \$500 copay per admission for unlimited days Covered in full Not covered Facility: Subject to \$500 copay; Physician: Subject to 20% coinsurance or \$300 copay, whichever is less Covered in full
<p>Emergency Care</p> <ul style="list-style-type: none"> Emergency room care Freestanding urgent care center Ambulance 	<ul style="list-style-type: none"> \$150 copay per visit, unless admitted within 24 hours \$50 copay per visit \$100 copay 	<ul style="list-style-type: none"> \$150 copay per visit, unless admitted within 24 hours \$50 copay per visit \$100 copay
<p>Outpatient Hospital Benefits</p>		



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