Excellus BlueCross BlueShield
Medical Benefits Summary 2009

Services		BluePPO Plan J in-network/ Out-of-network	BlueEPO Plan J	BluePPO HDHP with HRA In-Network/ Out-of-Network
EE Monthly Rates 2009	**1P**	**$82.70**	**$77.92**	**$40.98**
	2P	**$160.68**	**$151.32**	**$79.34**
	3+	**$221.28**	**$209.22**	**$108.90**
Prescription Drug:		$5 Generic	$5 Generic	10% Generic
		$15 Preferred Brand	$20 Preferred Brand	40% Preferred Brand
		$30 Non-Preferred Brand	$35 Non-Preferred Brand	50% Non-Preferred Brand
		90-day mail order 1x's copays	90-day mail order 1x's copays	30-day mail order for one copay
Co-Payment:		$20	$20	N/A
Deductible Levels:		No deductible / $750/$2,250	N/A	$1,300 per member/$2,600 per family
				UC contributes $1,000 single/ $2,000 family towards deductible
				full family deductible must be met before services are covered
Co-insurance:		N/A / 20% out-of-network	N/A	20% in-network / 40% out-network
Hospital - Inpatient:				
Semi-private room & board		Covered in full / 80% after deductible	covered in full	80% subject to deductible/ 60% subject to deductible
Maternity Care		Covered in full / 80% after deductible	$20 for initial visit then covered in full	80% subject to deductible/ 60% subject to deductible
Hospital for mother		Covered in full / 80% after deductible	Covered in full	80% subject to deductible/ 60% subject to deductible
Newborn Nursery Care Hosp		Covered in full / 80% after deductible	Covered in full	80% subject to deductible/ 60% subject to deductible
Physical Rehab (inpatient)		Covered in full / 80% after deductible	Covered in full (60 days-rider)	80% subject to deductible/ 60% subject to deductible
Medical Services / Consult.		Covered in full / 80% after deductible	Covered in full	80% subject to deductible/ 60% subject to deductible
Hospital - Outpatient:				
Ambulatory Surgery		$20 per visit / 80% after deductible	$20 per visit	80% subject to deductible/ 60% subject to deductible
Physician:				
Doctor's Office		$20 copay/visit / 80% after deductible	$20 per visit	80% subject to deductible/ 60% subject to deductible
Specialist's Office Visit		$20 copay/visit / 80% after deductible	$20 per visit	80% subject to deductible/ 60% subject to deductible
Chiropractic Services		$20 copay/visit / 80% after deductible	$20 per visit	80% subject to deductible/ 60% subject to deductible
Pap Smear		Covered in full / 80% after deductible	Covered in full	Covered in full
X-Ray Services		$20 copay/visit / 80% after deductible	$20 per visit	80% subject to deductible/ 60% subject to deductible
Laboratory Services		Covered in full / 80% after deductible	Covered in full	80% subject to deductible/ 60% subject to deductible
Mammography		Covered in full / 80% after deductible	Covered in full	Covered in full
Prenatal & Postnatal Maternity Care		Covered in full after $20 initial visit/80% after ded	$20 for initial visit then covered in full	80% subject to deductible/ 60% subject to deductible
Allergy Injections		Covered in full / 80% after deductible	Covered in full	80% subject to deductible/ 60% subject to deductible
Allergy Tests		$20 copay/visit / 80% after deductible	$20 per visit	80% subject to deductible/ 60% subject to deductible
Second Surgical Opinion		$20 copay/visit / 80% after deductible	$20 per visit	80% subject to deductible/ 60% subject to deductible
Prostate Cancer Screening		Covered in full/ 80% after deductible	Covered in full	Covered in full
Preventive:				
Adult Routine Physical (1yr)		$20 copay/visit / 80% after deductible	$20 per visit	Covered in full
Well-Child Care/Immunizations		Covered in full /Covered in full	Covered in full	Covered in full
Routine Gynecological Exam (1yr)		Covered in full / 80% after deductible	$20 per visit	Covered in full
Annual Pap Smear		Covered in full / 80% after deductible	Covered in full	Covered in full
One (1) Routine Vision Exam (every 2 yrs)		$20 per visit	$20 per visit	Not covered
One (1) Routine Hearing Exam		Not covered	Not covered	80% subject to deductible/ 60% subject to deductible
Alcohol/Substance Abuse - Outpatient:				
60 visits (20 visits for family therapy)		$20 copay/visit / 80% after deductible	$20 per visit	80% subject to deductible/ 60% subject to deductible
Mental Health- Inpatient:				
30 days		no deductible / 80% after deductible	covered in full	80% subject to deductible/ 60% subject to deductible
Mental Health- Outpatient:				
Individual Therapy 20 visits		50% coinsurance per visit /50% subj to deductible	50% coinsurance per visit	50% coinsurance per visit

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General:				
Kidney Dialysis		Covered in full / 80% after deductible	Covered in full	
MRI & MRA		$20 copay/visit (45 visits) / 80% after deductible	$20 per visit	80% subject to deductible/ 60% subject to deductible
PT,OT, ST, Cardiac Rehab, Pulmonary Therapy		$20 copay/visit (45 visits) / 80% after deductible	$20 per visit	80% subject to deductible/ 60% subject to deductible
Chemotherapy/Radiation		Covered in full / 80% after deductible	Covered in full	80% subject to deductible/ 60% subject to deductible
Ambulance (ground & air)		$20 per emergency /80% after deductible	$20 per emergency	80% subject to deductible/ 80% subject to deductible
Home Health Care		Covered in full /75% subj $50 deductible	Covered in full (unlimited visits)	80% subject to deductible/ 60% subject to deductible
Skilled Nursing Facility		Covered in full / 80% after deductible	Covered in full (120 days, Rider 45 days)	80% subject to deductible/ 60% subject to deductible
Diabetic Supplies		$20 copay on month supply/80% after deductible	$20 for 1 month supply	80% subject to deductible/ 60% subject to deductible
International Coverage:		Blue Card (same as your member ID card)	Blue Card (same as your member ID card)	Blue Card (same as your member ID card)
		Direct link to care anywhere in the country and many places overseas	Direct link to care anywhere in the country and many places overseas	Direct link to care anywhere in the country and many places overseas
Emergency:				
Medical Emergency		$50 copay/visit / $50 copay/visit	$50 per visit unless admitted within 24 hours	80% subject to deductible/ 80% subject to deductible
After hours PCP's office		$25 copay/visit / 80% after deductible	$20 copay	80% subject to deductible/ 60% subject to deductible
Freestanding Urgent Care Center		$25 copay/visit / 80% after deductible	$25 per visit	80% subject to deductible/ 60% subject to deductible
Additional Benefits:				
Durable Medical Equipment		Covered at 80%	Covered at 80%	80% subject to deductible/ 60% subject to deductible
External Prosthetic Appliances		Covered at 80%	Covered at 80% (up to $15,000 annual limit)-rider	80% subject to deductible/ 60% subject to deductible
Detoxification (7 inpatient days)		$500 copay(37 Days) / 80% after deductible	Covered in full-rider	80% subject to deductible/ 60% subject to deductible
Hospice		Covered in full / 80% after deductible	Covered in full	80% subject to deductible/ 60% subject to deductible
Student rider age 25		yes	yes	yes
Network		99% local coverage and 85% national coverage	99% local coverage and 85% national coverage	99% local coverage and 85% national coverage
Wellness Services		Over two dozen local wellness discounts and free health screens ava	Over two dozen local wellness discounts and free health screens avail	Over two dozen local wellness discounts and free health screens avail.
oopm		$2000/$6000 out of pocket maximum		$3000/$6000 out of pocket maximum (includes deductible)
This is a summary of benefits to be used for comparison only. Please refer to your contract booklet for full description of benefits and maximum benefit coverage or contact the Human Resources Office at Ext. 3024.				