

Comparison of benefits for Monroe Community College

type of care/plan features	BluePoint 2 Enhanced		BluePoint 2 Standard		Excellus BluePPO	
	In Network	Out Of Network	In Network	Out Of Network	In-Network	Out Of Network
<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 	<ul style="list-style-type: none"> Required Required Covered Coverage provided worldwide through the BlueCard® program. Qualified dependents and students are covered to age 26. Covered 	<ul style="list-style-type: none"> Required Required Covered Coverage provided worldwide through the BlueCard® program. Qualified dependents and students are covered to age 26. Covered 	<ul style="list-style-type: none"> Not required Not required Covered Coverage provided worldwide through the BlueCard® program. Qualified dependents and students are covered to age 26. Covered 			
<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"> \$15 copay \$15 copay In-network: None; Out-of-network: 20% In-Network: None; Out-of-Network: \$300 individual/\$600 2-person/\$750 family In-Network: None; Out-of-Network: \$3,000 individual/\$6,000 2-person/\$7,500 family None 	<ul style="list-style-type: none"> \$20 copay \$20 copay In-Network: None; Out-of-Network: 25% In-Network: None; Out-of-Network: \$500 individual/\$1,000 2-person/\$1,250 family In-Network: None; Out-of-Network: \$5,000 individual/\$10,000 2-person/\$12,500 family None 	<ul style="list-style-type: none"> \$10 copay \$10 copay In-network: 10% Out-of-network: 30% Combined in and out of network: \$250 individual/\$750 family Combined in and out of network: \$1,000 individual/\$3,000 family None 			
<p>Preventive Health Care Services</p> <ul style="list-style-type: none"> Well child visits Adult routine physical exams Adult immunizations Mammography Pap smear 	<ul style="list-style-type: none"> Covered in full \$15 copay per visit, limited to one exam per calendar year Covered in full Covered in full Covered in full 	<ul style="list-style-type: none"> Covered at 80%, subject to the deductible Covered at 80%, subject to the deductible for one routine exam per calendar year Not covered Covered at 80%, subject to the deductible Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> Covered in full \$20 copay per visit, limited to one exam per calendar year Covered in full \$20 copay \$20 copay 	<ul style="list-style-type: none"> Covered at 75%, subject to the deductible Not covered Not covered Covered at 75%, subject to the deductible Covered at 75%, subject to the deductible 	<ul style="list-style-type: none"> Covered in full \$10 copay per visit, limited to one per calendar year \$10 copay Covered in full Covered in full 	<ul style="list-style-type: none"> Covered in full Covered at 70%, subject to the deductible for one routine exam per calendar year Not covered Covered at 70%, subject to the deductible Covered at 70%, subject to the deductible

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<ul style="list-style-type: none"> • Routine GYN exam • Prostate cancer screening • Routine vision 	<ul style="list-style-type: none"> • Covered in full • \$15 copay • \$15 copay for one routine exam every 2 years; every year for children to age 19. \$60 eyewear allowance per member in any 12-month period. 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible • Routine eye exams are not covered. \$60 eyewear allowance per member in any 12-month period. 	<ul style="list-style-type: none"> • \$20 copay • \$20 copay • \$20 copay for one routine eye exam every 2 years; every year for dependents to age 19. \$60 eyewear allowance per member in any 12-month period. 	<ul style="list-style-type: none"> • Covered at 75%, subject to the deductible • Covered at 75%, subject to the deductible • Routine eye exams are not covered. \$60 eyewear allowance per member in any 12-month period. 	<ul style="list-style-type: none"> • Covered in full • \$10 copay • \$10 copay for one routine exam every 2 years; \$60 eyewear allowance available every 2 years 	<ul style="list-style-type: none"> • Covered at 70%, subject to the deductible • Covered at 70%, subject to the deductible • Covered at 70%, subject to the deductible for one routine exam every 2 years. \$60 eyewear allowance available every 2 years
Physician Office Services						
<ul style="list-style-type: none"> • Diagnostic office visits • Diagnostic x-rays 	<ul style="list-style-type: none"> • \$15 copay per visit • \$15 copay per visit 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> • \$20 copay per visit • \$20 copay per visit 	<ul style="list-style-type: none"> • Covered at 75%, subject to the deductible • Covered at 75%, subject to the deductible 	<ul style="list-style-type: none"> • \$10 copay per visit • Covered at 90%, subject to the deductible. Precertification applies to MRI, PET and CAT scans. 	<ul style="list-style-type: none"> • Covered at 70%, subject to the deductible • Covered at 70%, subject to the deductible. Precertification applies to MRI, PET and CAT scans.
<ul style="list-style-type: none"> • Diagnostic laboratory and pathology • Allergy tests • Allergy injections • Chemotherapy • Radiation therapy 	<ul style="list-style-type: none"> • Covered in full • \$15 copay per visit • \$15 copay per visit • Covered in full • Covered in full 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> • Covered in full • \$20 copay per visit 	<ul style="list-style-type: none"> • Covered at 75%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 90%, subject to the deductible • \$10 copay per visit • Covered in full • Covered at 90%, subject to the deductible • Covered at 90%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 70%, subject to the deductible
Maternity Services						

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<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"> • Covered in full • Covered in full • Covered in full 	<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"> • \$5 copay per visit for first 10 visits, remainder of visits are covered in full • Hospital-Subject to \$100 copay per admission; Delivery-Covered in full • Covered in full 	<ul style="list-style-type: none"> • Covered at 75%, subject to the deductible • Covered at 75%, subject to the deductible • Covered at 75%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 90%, subject to the deductible • Covered at 90%, subject to the deductible • Covered at 90% 	<ul style="list-style-type: none"> • Covered at 70%, subject to the deductible • Covered at 70%, subject to the deductible • Covered at 70%, subject to the deductible
<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"> • \$5/\$20/\$35 	<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • \$10/\$25/\$40 	<ul style="list-style-type: none"> • Not covered 	<ul style="list-style-type: none"> • \$10/\$25/\$40 	<ul style="list-style-type: none"> • Not covered
<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"> • Covered in full for unlimited days • Covered in full • Covered at 100% for up to 60 days per calendar year • Covered in full • Covered in full 	<ul style="list-style-type: none"> • Covered at 80%, subject to the deductible. Precertification applies. • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible for up to 60 days per calendar year. Precertification applies. • Covered at 80%, subject to the deductible • Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> • Subject to \$100 copay per admission for unlimited days • Covered in full • Subject to \$100 copay per admission for 60 days per calendar year • Covered in full • Covered in full 	<ul style="list-style-type: none"> • Covered at 75%, subject to the deductible • Covered at 75%, subject to the deductible • Covered at 75%, subject to the deductible for up to 60 days per calendar year. Precertification applies. • Covered at 75%, subject to the deductible • Covered at 75%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 90%, subject to the deductible. Precertification applies. • Covered at 90%, subject to the deductible • Covered at 100% for up to 60 days per calendar year • Covered at 90%, subject to the deductible • Covered at 90%, subject to the deductible 	<ul style="list-style-type: none"> • Covered at 70%, subject to the deductible. Precertification applies. • Covered at 70%, subject to the deductible • Covered at 70%, subject to the deductible for up to 60 days per calendar year. Precertification applies. • Covered at 70%, subject to the deductible • Covered at 70%, subject to the deductible
<p>Emergency Care</p>						

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<ul style="list-style-type: none"> Emergency room care Freestanding urgent care center Ambulance 	<ul style="list-style-type: none"> \$75 copay per visit, unless admitted within 24 hours \$25 copay per visit \$75 copay 	<ul style="list-style-type: none"> \$75 copay per visit, unless admitted within 24 hours Covered at 80%, subject to the deductible \$75 copay 	<ul style="list-style-type: none"> \$100 copay per visit, unless admitted within 24 hours \$25 copay per visit \$20 copay 	<ul style="list-style-type: none"> \$100 copay per visit, unless admitted within 24 hours Covered at 75%, subject to the deductible \$20 copay 	<ul style="list-style-type: none"> \$50 copay per visit, unless admitted within 24 hours \$25 copay per visit \$50 copay 	<ul style="list-style-type: none"> \$50 copay per visit, unless admitted within 24 hours Covered at 70%, subject to the deductible \$50 copay
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"> \$15 copay per visit Covered in full Facility: Covered in full; Physician: \$15 copay Covered in full Covered in full 	<ul style="list-style-type: none"> Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> \$20 copay per visit Covered in full Facility: \$50 copay; Physician: \$20 copay \$20 copay per visit \$20 copay per visit 	<ul style="list-style-type: none"> Covered at 75%, subject to the deductible 	<ul style="list-style-type: none"> Covered at 90%, subject to the deductible. Precertification applies to MRI, PET and CAT scans Covered at 90%, subject to the deductible 	<ul style="list-style-type: none"> Covered at 70%, subject to the deductible. Precertification applies to MRI, PET and CAT scans Covered at 70%, 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"> Covered in full \$15 copay. Services can be provided in an outpatient facility or in a provider office. 	<ul style="list-style-type: none"> Covered at 80%, subject to the deductible. Precertification applies. Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> Subject to \$100 copay per admission \$20 copay per visit. Services can be provided in an outpatient facility or in a provider office. 	<ul style="list-style-type: none"> Covered at 75%, subject to the deductible. Precertification applies. Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> Covered at 90%, subject to the deductible. Precertification applies. \$10 copay. Services can be provided in an outpatient facility or in a provider office. 	<ul style="list-style-type: none"> Covered at 70%, subject to the deductible. Precertification applies. Covered at 70%. Services can be provided in an outpatient facility or in a provider's office.

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<ul style="list-style-type: none"> Inpatient chemical dependence Outpatient chemical dependence 	<ul style="list-style-type: none"> Covered in full \$15 copay per visit 	<ul style="list-style-type: none"> Covered at 80%, subject to the deductible. Precertification applies. Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> Subject to \$100 copay per admission \$20 copay per visit 	<ul style="list-style-type: none"> Covered at 75%, subject to the deductible. Precertification applies. Covered at 75%, subject to the deductible 	<ul style="list-style-type: none"> Covered at 90%, subject to the deductible. Precertification applies. Covered at 90%, subject to the deductible 	<ul style="list-style-type: none"> Covered at 70%, subject to the deductible. Precertification applies. Covered at 70%, subject to the deductible
Other Services						
<ul style="list-style-type: none"> Diabetic insulin and supplies Skilled nursing facility Home care Hospice Outpatient therapy Durable medical equipment 	<ul style="list-style-type: none"> \$15 copay for up to a 30 day supply Covered in full for up to 45 days per calendar year Covered in full for unlimited visits 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% 	<ul style="list-style-type: none"> Covered at 80%, subject to the deductible for up to a 30 day supply Covered at 80%, subject to the deductible for up to 45 days per calendar year. Precertification applies. Covered at 80%, subject to a \$50 deductible for unlimited visits per calendar year. Precertification applies. Covered at 80%, subject to the deductible for unlimited visits per calendar year 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 50%, subject to the deductible 	<ul style="list-style-type: none"> \$20 copay for up to a 30 day supply Covered in full for up to 45 days per calendar year Covered in full for unlimited visits Covered in full for unlimited days \$20 copay per visit for up to a combined 45 visits for physical, speech and occupational therapy Covered at 80% 	<ul style="list-style-type: none"> Covered at 75%, subject to the deductible for up to a 30 day supply Covered at 75%, subject to the deductible for up to 45 days per calendar year. Precertification applies. Covered at 75%, subject to a \$50 deductible for unlimited visits per calendar year. Precertification applies. Covered at 75%, subject to the deductible for unlimited visits per calendar year Covered at 75%, subject to the deductible for a combined total of 45 visits per calendar year for physical, speech and occupational therapy Covered at 50%, subject to the deductible 	<ul style="list-style-type: none"> \$10 copay for up to a 30 day supply Covered at 90%, subject to the deductible for up to 120 days per calendar year. Precertification applies. Covered at 90%, subject to a \$50 deductible for unlimited visits per calendar year. Precertification applies. Covered at 90% for unlimited visits per calendar year. Covered at 90%, subject to the deductible for a combined total of 45 visits per calendar year for physical, speech, occupational and respiratory therapy Covered at 90%, subject to the deductible. Precertification applies. 	<ul style="list-style-type: none"> Covered at 70%, subject to the deductible for up to a 30 day supply Covered at 70%, subject to the deductible for up to 120 days per calendar year. Precertification applies. Covered at 75%, subject to a \$50 deductible for unlimited visits per calendar year. Precertification applies. Covered at 70% for unlimited visits per calendar year. Covered at 70%, subject to the deductible for a combined total of 45 visits per calendar year for physical, speech, occupational and respiratory therapy Covered at 70%, subject to the deductible. Precertification applies.

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<ul style="list-style-type: none"> External prosthetics 	<ul style="list-style-type: none"> Covered at 80%, up to \$15,000 per calendar year 	<ul style="list-style-type: none"> Covered at 50%, subject to the deductible, for up to a \$15,000 calendar year maximum. Precertification applies. 	<ul style="list-style-type: none"> Covered at 80%, up to \$15,000 per calendar year 	<ul style="list-style-type: none"> Covered at 50%, subject to the deductible for up to \$15,000 maximum per calendar year 	<ul style="list-style-type: none"> Covered at 90%, subject to the deductible, for up to \$15,000 per calendar year 	<ul style="list-style-type: none"> Covered at 70%, subject to the deductible, for up to \$15,000 per calendar year
<ul style="list-style-type: none"> Chiropractic 	<ul style="list-style-type: none"> \$15 copay per visit 	<ul style="list-style-type: none"> Covered at 80%, subject to the deductible 	<ul style="list-style-type: none"> \$20 copay per visit 	<ul style="list-style-type: none"> Covered at 75%, subject to the deductible 	<ul style="list-style-type: none"> \$10 copay per visit 	<ul style="list-style-type: none"> Covered at 70%, subject to the deductible
<ul style="list-style-type: none"> Acupuncture 	<ul style="list-style-type: none"> Covered at 50% for up to 10 visits per calendar year 	<ul style="list-style-type: none"> Covered at 50%, subject to the deductible, for up to 10 visits per calendar year 	<ul style="list-style-type: none"> Covered at 50% for up to 10 visits per calendar year 	<ul style="list-style-type: none"> Covered at 50%, subject to the deductible, for up to 10 visits per calendar year 	<ul style="list-style-type: none"> Not covered 	<ul style="list-style-type: none"> Not covered
<ul style="list-style-type: none"> Dental 	<ul style="list-style-type: none"> \$15 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly 	<ul style="list-style-type: none"> Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly 	<ul style="list-style-type: none"> \$20 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly 	<ul style="list-style-type: none"> Covered at 75%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly 	<ul style="list-style-type: none"> Covered at 90%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly 	<ul style="list-style-type: none"> Covered at 70%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly
<ul style="list-style-type: none"> Hearing 	<ul style="list-style-type: none"> \$15 copay for one routine hearing exam per calendar year. Hearing aids covered up to \$600 for up to 2 hearing aids every 3 years for children to age 19. 	<ul style="list-style-type: none"> Routine exams not covered 	<ul style="list-style-type: none"> \$20 copay for one routine hearing exam per calendar year. Hearing aids covered up to \$600 for up to 2 hearing aids every 3 years for children to age 19. 	<ul style="list-style-type: none"> Routine exams not covered 	<ul style="list-style-type: none"> Routine exams not covered 	<ul style="list-style-type: none"> Routine exams not covered