

2008 Comparison of Health Insurance Plan Highlights

BENEFIT	BLUE POINT 2 VALUE	BLUE POINT 2 SELECT - 1	BLUE POINT 2 SELECT – 2 *CSEA ONLY*	BLUE POINT 2 EXTENDED – 1 *Firefighters, IUOE & Sheriff’s Sworn Only*	BCBS
Primary Care Doctor Office Visits	\$20 co-pay	\$15 co-pay	\$15 co-pay	\$5 co-pay	\$100 deductible per year 20% co-insurance
Specialist Doctor Office Visits	\$20 co-pay	\$15 co-pay	\$15 co-pay	\$10 co-pay	\$100 deductible per year 20% co-insurance
Sick Child Doctor Visits	\$20 co-pay	\$5 until age 5 \$15 after age 5	Covered in full under age 5 \$10 ages 5 – 18 \$15 ages 19 and up	\$5 co-pay	\$100 deductible per year 20% co-insurance
Well Child Doctor Visits	Covered in full until age 19	Covered in full until age 19	Covered in full until age 19	Covered in full until age 19	Covered in full until age 19
Eye Exams Eye Wear	\$20 co-pay, \$60 toward glasses or contacts every two years; under age 19 yearly	\$15 co-pay, \$60 toward glasses or contacts every two years; under age 19 yearly	\$15 co-pay for routine eye exams every calendar year; \$60 toward glasses or contacts every year	\$10 co-pay, \$60 toward glasses or contacts every two years; under age 19 yearly	No coverage
Hospitalization	\$100 co-pay per admission	Covered in full	Covered in full	Covered in full	\$100 deductible per year. 120 days covered, after 120 days, 20% co- insurance
Emergency Care	\$50 co-pay unless admitted within 24 hrs	\$50 co-pay unless admitted within 24 hrs.	\$50 co-pay unless admitted within 24 hrs.	\$50 co-pay unless admitted within 24 hrs.	Covered in full
Freestanding Urgent Care (After Hours)	\$25 co-pay per visit	\$25 co-pay per visit	\$25 co-pay per visit	\$25 co-pay per visit	\$100 deductible per year 20% co-insurance
Adult Physicals	\$20 co-pay	\$15 co-pay	\$15 co-pay	Covered in full	No coverage
Mammograms	\$20 co-pay	Covered in full	Covered in full	Covered in full	\$100 deductible per year 20% co-insurance
Gynecological Exams	\$20 co-pay	Exam \$15 co-pay	Exam \$15 co-pay	Exam covered in full	Annual Pelvic Exam & Pap Smear only covered, no physical coverage

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Guest Services	Guest Services program - In network coverage available when living away from home for at least 90 consecutive days	Guest Services program - In network coverage available when living away from home for at least 90 consecutive days	Guest Services program - In network coverage available when living away from home for at least 90 consecutive days	Guest Services program - In network coverage available when living away from home for at least 90 consecutive days	Coverage world wide provided
Dependent Coverage	Qualified dependents covered to age 19. Full-time students to age 23	Qualified dependents covered to age 19. Full-time students to age 23	Qualified dependents covered to age 19. Full-time students to age 23	Qualified dependents covered to age 19. Full-time students to age 23	Qualified dependents covered to age 19. Full-time students to age 23
Prescription Drugs	Retail and Mail Order Tier 1-generic, \$10 Tier 2-brand name, \$25 Tier 3-higher cost brand, \$40 <i>See the 3-Tier Drug Class Guide</i>	Retail and Mail Order Tier 1-generic, \$5 Tier 2-brand name, \$20 Tier 3-higher cost brand, \$35 <i>See the 3-Tier Drug Class Guide</i>	Retail Up to 90-day supply covered at 50%. Mail Order Up to a 90 day supply Covered with a \$15 co-pay for generic prescription drugs and \$75 co-pay for brand name	Retail and Mail Order Tier 1-generic, \$5 Tier 2-brand name, \$15 Tier 3-higher cost brand, \$30 <i>See the 3-Tier Drug Class Guide</i>	Retail and Mail Order \$3 co-pay, generic \$6 co-pay, brand name, up to 30 day supply
Outpatient Mental Health	\$20 co-pay for up to 20 visits per member per calendar year, combined with outpatient facility. No coverage for ongoing psychotherapy, marital or family counseling or group therapy. Combined total includes in and out of network	\$15 co-pay for up to 20 visits per member per calendar year combined with outpatient facility. No coverage for ongoing psychotherapy, marital or family counseling or group therapy	\$15 co-pay for up to 20 visits per calendar year combined with outpatient facility. No coverage for ongoing psychotherapy, marital or family counseling or group therapy	\$10 co-pay for up to 20 visits, combined with facility per member per calendar year. No coverage for ongoing psychotherapy, marital or family counseling or group therapy	Covered at 100% for up to 20 visits per member per calendar year. Once basic exhausts, covered at 50%, subject to the deductible, up to 40 visits per member per calendar year. Services must be rendered by a licensed psychiatrist, psychologist, certified social worker or approved facility
Durable Medical Equipment	Standard equipment covered 80% when purchased from a participating provider. Diabetic DME is covered in full.	Standard equipment covered 80% when purchased from a participating provider. Diabetic DME covered in full.	DME is limited to 80% of covered expenses and provided up to \$15,000 per member per calendar year when purchased for participating provider. Coverage for custom made orthotics is limited to 50% of covered expenses and provided up to a maximum benefit of \$250 per pair per member every 3 years	Standard equipment covered 80% when purchased from a participating provider. Diabetic DME covered in full	Standard equipment covered at 100% of the Scheduled Allowances, subject to the deductible, when ordered by your physician and obtained from a Participating Provider. If DME is obtained from a Non-Participating Provider it will be covered at 50% of the charge, subject to the deductible