

**Product Comparison : BlueCare Cooperative + Major Medical
Compared to New BlueCare Assure Products**

Product Name	Cooperative	Major Medical	BlueCare Assure
<i>Product type</i>	<i>Traditional</i>	<i>Traditional</i>	<i>PPO</i>
<i>Product Available:</i>	1979	1979	10/1/2008
<u>Benefits</u>			
Deductible: All services are subject to the deductible unless otherwise noted	Blue Cross (Hospital): None Blue Shield (Physician): \$250 individual/\$750 family	\$500 medical \$500 Rx	<u>In-network Options:</u> \$500 / \$1000 / \$2000 / \$4000 <u>Out-of-Network Options</u> \$1000/\$2000/\$4000/\$8000
Coinsurance: Amount plan will pay after deductible	No Coinsurance for participating facilities 70% at non-participating facilities	80%	In-network: 80% Out-of-network: 50%
Out of Pocket Max	none	none	<u>In-network</u> \$1500/\$2000/\$3000/\$5000 <u>Out-of-network</u> \$1000/\$2000/\$4000/\$8000
Calendar Year Max	Blue Cross: none BlueShield: \$1,000,000	none	none
Lifetime Max	Blue Cross: none BlueShield: \$5,000,000	none	\$5,000,000
Precert Penalty	none	none	none
			In-Network Benefits
Allergy Extracts/Injections		80% coinsurance	80% coinsurance
Ambulance (emergency)	not covered	80% coinsurance	100% not subject to deductible or coinsurance \$3000 max per calendar year combined emergency and non-emergency transports
Ambulance (non-emergency)	not covered	80% coinsurance	80% coinsurance
Anesthesia	100%	80% coinsurance	80% coinsurance
Breast Reconstruction	100%	80% coinsurance	80% coinsurance
Cardiac Rehab	100% Limited to 36 visits per calendar year	not covered	80% coinsurance limited to 20 visits per calendar year for combined with physical, speech, occupational, chiropractic, respiratory, and pulmonary
Chemotherapy	100%	80% coinsurance	80% coinsurance
Chiropractic Care	not covered	80% coinsurance limited to 45 visits per calendar year for combined physical, speech, occupational and chiropractic care	80% coinsurance limited to 20 visits per calendar year for combined physical, speech, occupational, chiropractic, respiratory, pulmonary and cardiac rehab
Cholesterol Screening	not covered	not covered	80% coinsurance
Circumcision (routine neonatal)	100%	80% coinsurance	80% coinsurance
Colonoscopy (diagnostic)	100%	80% coinsurance	80% coinsurance
Colonoscopy (routine)	not covered	not covered	80% coinsurance only not subject to the deductible

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Complications of Pregnancy	100%	80% coinsurance	80% coinsurance
Consultations (inpatient)	100%	80% coinsurance	80% coinsurance
Consultations (outpatient)	not covered	80% coinsurance	primary care: \$25 copay specialist: \$50 copay limited to 4 visits per calendar year (combined with office visits)
Diabetic Education	100%	80% coinsurance	80% coinsurance
Diabetic Supplies	100%	80% coinsurance	covered under Rx benefits
Dialysis	100%	80% coinsurance	80% coinsurance
Diagnostic Lab	\$15 copay covered 100% of the allowed amount after the copay	80% coinsurance	80% coinsurance
Diagnostic Xray	\$75 copay for MRI, MRA, Ct Scan, Pet Scan and nuclear cardiology \$15 copay for all other testing	80% coinsurance	80% coinsurance
DME, Prosthetics & Orthotics	not covered except mandated mastectomy and diabetic related items 100%	80% coinsurance \$2500 max per calendar year	not covered except for mandated diabetic and mastectomy related equipment and supplies 80% coinsurance
Emergency Medical Emergency Accident	\$75 copay covered 100% after the copay	100% not subject to any deductible or coinsurance	\$150 copay Covered 100% allowed amount after copay
Female Exam (diagnostic)	100%	80% coinsurance	80% coinsurance
Female Exam (routine)	100%	80% coinsurance	\$50 copay covered 100% allowed amount after the copay
Hearing Aids	not covered	not covered	not covered
Hearing Exam	not covered	not covered	not covered
Home Health	100% Limited to 100 visits per calendar year	80% coinsurance	80% coinsurance Limited to 100 visits per calendar year
Home Health (post-partum)	100%	100%	100% not subject to deductible or coinsurance
Home Infusion	100%	not covered	80% coinsurance
Hospice	100% / \$5000 lifetime max Respite Care limited to 5 days in a 3 month period	not covered	80% coinsurance
Immunizations (adult)	Not covered	not covered	80% coinsurance coverage for medically necessary immunizations only
Immunizations (pediatric)	100%	80% coinsurance only not subject to the deductible	100% not subject to deductible or coinsurance
Inpatient Facility Services	\$100 copay per admission plus \$25 copay per day for first 15 days of hospitalization then covered at 100% of the allowed amount	not covered	80% coinsurance
Mammogram (diagnostic)	\$15 copay then covered at 100% of the allowed amount	80% coinsurance	80% coinsurance
Mammogram (routine)	\$15 copay then covered at 100% of the allowed amount	80% coinsurance	80% coinsurance only not subject to the deductible
Massage Therapy	not covered	not covered	not covered

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Mastectomy	100%	80% coinsurance	80% coinsurance
Maternity (inpatient)	100%	80% coinsurance	not covered
Maternity (outpatient)	100%	80% coinsurance	not covered
Mental Health (outpatient)	100%	50% coinsurance \$25,000 lifetime max	not covered
Mental Health (inpatient)	\$100 copay per admission \$25 copay per day for first 15 days of hospitalization covered 100% of the allowed amount after the copays limited to 30 days per calendar year	50% coinsurance \$25,000 lifetime max	not covered
Occupational Therapy	not covered	80% coinsurance limited to 45 visits per calendar year for combined physical, speech, occupational and chiropractic care	80% coinsurance Limited to 20 visits per calendar year for combined physical, speech, occupational, chiropractic, respiratory, pulmonary and cardiac rehab
Office Visits (non-routine)	not covered	80% coinsurance	primary care: \$25 copay specialist: \$50 copay limited to 4 visits per calendar year (combined with outpatient consultations)
Oxygen related Equipment & Supplies	not covered	80% coinsurance	80% coinsurance
Physical Therapy	not covered	80% coinsurance limited to 45 visits per calendar year for combined physical, speech, occupational and chiropractic care	80% coinsurance Limited to 20 visits per calendar year for combined physical, speech, occupational, chiropractic, respiratory, pulmonary and cardiac rehab
Physical Rehab (inpatient)	\$100 copay per admission \$25 copay per day for first 15 days of hospitalization covered 100% of the allowed amount after the copays	80% coinsurance	80% coinsurance Limited to 45 days per calendar year
Prescription Drugs	not covered	\$500 deductible Retail Tier 0: \$0 copay Tier 1: \$15 copay Tier 2: \$30 copay Tier 3: \$50 copay Mail Order Tier 0: \$0 copay Tier 1: \$30 copay Tier 2: \$75 copay Tier 3: \$150 copay	\$200 deductible Retail Tier 0: \$0 copay Tier 1: \$20 copay Tier 2: \$40 copay Tier 3: \$60 copay Mail Order Tier 0: \$0 copay Tier 1: \$40 copay Tier 2: \$100 copay Tier 3: \$150 copay
Preventive Care (adult)	not covered	not covered	not covered
Preventive Care (pediatric)	not covered	80% coinsurance	80% coinsurance only not subject to the deductible
Private Duty Nursing	not covered	not covered	not covered
Prostate Screening	not covered	not covered	80% coinsurance only not subject to the deductible
Pulmonary Rehab	100% limited to 90 days following inpatient SPU stay	80% coinsurance unlimited days	80% coinsurance Limited to 20 visits per calendar year for combined physical, speech, occupational, chiropractic, respiratory, pulmonary and cardiac rehab
Radiation Therapy	100%	80% coinsurance	80% coinsurance

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Respiratory Therapy	100% limited to 90 days following inpatient SPU stay	80% coinsurance unlimited days	80% coinsurance Limited to 20 visits per calendar year for combined physical, speech, occupational, chiropractic, respiratory, pulmonary and cardiac rehab
Second Opinion	100%	80% coinsurance	80% coinsurance
Skilled Nursing	100% limited to 180 days per calendar year	80% coinsurance MM will cover charges beyond what Cooperative and Student allow	80% coinsurance Limited to 14 days per calendar year
Speech Therapy	not covered	80% coinsurance limited to 45 visits per calendar year for combined physical, speech, occupational and chiropractic care	80% coinsurance Limited to 20 visits per calendar year for combined physical, speech, occupational, chiropractic, respiratory, pulmonary and cardiac rehab
Substance Abuse (inpatient)	100% Limited to 7 days per detox admission w/4 admission lifetime max and 30 days per calendar year per inpatient rehab w/90 lifetime max inpatient facility services copays apply	not covered	not covered
Substance Abuse (outpatient)	100% Limited to 30 visits per calendar year w/120 day lifetime max	not covered	not covered
Surgery (inpatient)	100%	80% coinsurance	80% coinsurance
Surgery (outpatient)	100%	80% coinsurance	80% coinsurance
Transplants	100%	80% coinsurance	80% coinsurance
Vision Services	not covered	not covered	not covered
Rates			
	<u>Cooperative</u>	<u>Major Medical</u>	<u>Assure</u>
Individual	\$399.48	Cooperative: \$132.72	Child through age 18: Option 1: \$118.96 Option 2: \$109.50 Option 3: \$96.24 Option 4: \$81.00 Adult (18 years+): Option 1: \$390.74 Option 2: \$352.79 Option 3: \$299.60 Option 4: \$238.46
Family	\$842.69	Cooperative: \$280.25	n/a