

**Excellus BluePPO benefits**

**Prepared for Fulmont Trust Low Opt eff 7-1-10**

**4/9/2010**

Type of Care/Plan Benefits	In-Network	Out Of Network
<p><b>Plan features</b></p> <ul style="list-style-type: none"> <li>• <b>Primary Care Physician (PCP)</b></li> <li>• <b>Referrals</b></li> <li>• <b>Out of network benefits</b></li> <li>• <b>Out of area benefits</b></li> <li>• <b>Student/Dependent coverage</b></li> <li>• <b>Domestic partner</b></li> </ul> <p><b>Plan cost-sharing highlights</b></p> <ul style="list-style-type: none"> <li>• <b>Office visit copay (Primary Care Physician)</b></li> <li>• <b>Office visit copay (Specialist)</b></li> <li>• <b>Coinsurance</b></li> <li>• <b>Deductible</b></li> <li>• <b>Out of pocket maximum</b></li> <li>• <b>Lifetime maximum</b></li> </ul>	<ul style="list-style-type: none"> <li>• Not required</li> <li>• Not required</li> <li>• Covered</li> <li>• Coverage provided worldwide through the BlueCard® program.</li> <li>• Qualified dependents are covered to age 19. Qualified students are covered to age 25.</li> <li>• Not covered</li>   <li>• \$20 copay</li>   <li>• \$20 copay</li> <li>• In-network: None; Out-of-network: 30%</li> <li>• In-network: None Out of Network \$750 individual /\$2,250 family</li> <li>• In-network: None; Out of Network \$2,000 individual /\$6,000 family</li> <li>• None</li> </ul>	

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<p><b>Preventive Health Care Services</b></p> <ul style="list-style-type: none"> <li>• <b>Well child visits</b></li> <li>• <b>Adult routine physical exams</b></li>   <li>• <b>Adult immunizations</b></li> <li>• <b>Mammography</b></li> <li>• <b>Pap smear</b></li> <li>• <b>Routine GYN exam</b></li> <li>• <b>Prostate cancer screening</b></li> <li>• <b>Routine vision</b></li>   <li>• <b>Colonoscopy</b></li> </ul> <p><b>Physician Office Services</b></p> <ul style="list-style-type: none"> <li>• <b>Diagnostic office visits</b></li> <li>• <b>Diagnostic x-rays</b></li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full</li> <li>• \$20 copay per visit, limited to one exam per calendar year</li>   <li>• \$20 copay per visit</li>   <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• \$20 copay</li> <li>• \$20 copay for one routine eye exam every year. \$100 eyewear allowance every year.</li> <li>• Preventive and diagnostic covered according to the surgical benefit</li>   <li>• \$20 copay per visit</li> <li>• \$20 copay. Precertification applies to MRI, PET and CAT scans.</li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full</li> <li>• Covered at 70%, subject to the deductible for one routine exam per calendar year</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible for one routine exam per calendar year. \$100 eyewear allowance available per calendar year</li> <li>• Covered at 70%, subject to the deductible</li>   <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible. Precertification applies to MRI, PET and CAT scans.</li> </ul>

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<ul style="list-style-type: none"> <li>• <b>Diagnostic laboratory and pathology</b></li> <li>• <b>Allergy tests</b></li> <li>• <b>Allergy injections</b></li> <li>• <b>Chemotherapy</b></li> <li>• <b>Radiation therapy</b></li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full</li> <li>• \$20 copay per visit</li> <li>• Covered in full</li> <li>• Covered in full</li> <li>• Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> </ul>
<p><b>Maternity Services</b></p> <ul style="list-style-type: none"> <li>• <b>Prenatal and postpartum care</b></li> <li>• <b>Hospital care for mom (including delivery)</b></li> <li>• <b>Newborn nursery care</b></li> </ul>	<ul style="list-style-type: none"> <li>• \$20 copay per visit for initial visit, remainder of visits covered in full</li> <li>• Hospital-Covered in full; Delivery-Covered in full</li> <li>• Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> </ul>
<p><b>Prescription Drug</b></p> <ul style="list-style-type: none"> <li>• <b>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.</b></li> </ul>	<ul style="list-style-type: none"> <li>• \$10/\$25/\$40</li> </ul>	<ul style="list-style-type: none"> <li>• Not covered</li> </ul>
<p><b>Inpatient Hospital Benefits</b></p> <ul style="list-style-type: none"> <li>• <b>Hospital benefits</b></li> <li>• <b>Physician visits in the hospital</b></li> <li>• <b>Inpatient physical rehabilitation</b></li> <li>• <b>Surgery</b></li> <li>• <b>Anesthesia</b></li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full for unlimited days. Precertification applies.</li> <li>• Covered in full</li> <li>• Covered in full for up to 60 days per calendar year. Precertification applies.</li> <li>• Covered in full</li> <li>• Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 70%, subject to the deductible. Precertification applies.</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible for up to 60 days per calendar year. Precertification applies.</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> </ul>
<p><b>Emergency Care</b></p> <ul style="list-style-type: none"> <li>• <b>Emergency room care</b></li> <li>• <b>Freestanding urgent care center</b></li> <li>• <b>Ambulance</b></li> </ul>	<ul style="list-style-type: none"> <li>• \$50 copay per visit, unless admitted within 24 hours</li> <li>• \$25 copay per visit</li> <li>• \$20 copay</li> </ul>	<ul style="list-style-type: none"> <li>• \$50 copay per visit, unless admitted within 24 hours</li> <li>• Covered at 70%, subject to the deductible</li> <li>• \$20 copay</li> </ul>
<p><b>Outpatient Hospital Benefits</b></p> <ul style="list-style-type: none"> <li>• <b>Diagnostic x-rays</b></li> </ul>	<ul style="list-style-type: none"> <li>• \$20 copay per visit. Precertification applies to MRI, PET and CAT scans.</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 70%, subject to the deductible. Precertification applies to MRI, PET and CAT scans</li> </ul>

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<ul style="list-style-type: none"> <li>• <b>Diagnostic laboratory and pathology</b></li> <li>• <b>Surgical care</b></li> <li>• <b>Chemotherapy</b></li> <li>• <b>Radiation therapy</b></li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full</li> <li>• \$20 copay</li> <li>• Covered in full</li> <li>• Covered in full</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Covered at 70%, subject to the deductible</li> </ul>
<p><b>Mental Health and Chemical Dependence</b></p> <ul style="list-style-type: none"> <li>• <b>Inpatient mental health care</b></li> <li>• <b>Outpatient mental health care</b></li>   <li>• <b>Inpatient chemical dependence</b></li> <li>• <b>Outpatient chemical dependence</b></li> </ul>	<ul style="list-style-type: none"> <li>• Covered in full for unlimited days. Precertification applies.</li> <li>• \$20 copay. Services can be provided in an outpatient facility or in a provider office.</li>   <li>• Covered in full for unlimited days. Precertification applies.</li> <li>• \$20 copay per visit</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 70%, subject to the deductible. Precertification applies.</li> <li>• Covered at 70%, subject to the deductible. Services can be provided in an outpatient facility or in a provider office.</li> <li>• Covered at 70%, subject to the deductible. Precertification applies.</li> <li>• Covered at 70%, subject to the deductible</li> </ul>
<p><b>Other Services</b></p> <ul style="list-style-type: none"> <li>• <b>Diabetic insulin and supplies</b></li> <li>• <b>Skilled nursing facility</b></li>   <li>• <b>Home care</b></li>   <li>• <b>Hospice</b></li>   <li>• <b>Outpatient therapy</b></li>   <li>• <b>Durable medical equipment</b></li> <li>• <b>External prosthetics</b></li>   <li>• <b>Chiropractic</b></li> <li>• <b>Acupuncture</b></li> <li>• <b>Dental</b></li>   <li>• <b>Hearing</b></li> </ul>	<ul style="list-style-type: none"> <li>• \$20 copay for up to a 30 day supply</li> <li>• Covered in full for up to 120 days per calendar year. Precertification applies.</li> <li>• Covered in full for unlimited visits. Precertification applies.</li>   <li>• Covered in full for unlimited days</li>   <li>• \$20 copay for up to a combined total of 45 visits per calendar year for physical, speech, respiratory and occupational therapy</li> <li>• Covered at 80%. Precertification applies.</li> <li>• Covered at 80%, up to \$15,000 per calendar year</li>   <li>• \$20 copay per visit</li> <li>• Not covered</li> <li>• \$20 copay for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly</li>   <li>• Routine exams not covered</li> </ul>	<ul style="list-style-type: none"> <li>• Covered at 70%, subject to the deductible for up to a 30 day supply</li> <li>• Covered at 70%, subject to the deductible for up to 120 days per calendar year. Precertification applies.</li> <li>• Covered at 75%, subject to a \$50 deductible for unlimited visits per calendar year. Precertification applies.</li> <li>• Covered at 70%, subject to the deductible for unlimited visits per calendar year</li> <li>• Covered at 70%, subject to the deductible for a combined total of 45 visits per calendar year for physical, speech, occupational and respiratory therapy</li> <li>• Covered at 70%, subject to the deductible. Precertification applies.</li> <li>• Covered at 70%, subject to the deductible, for up to \$15,000 per calendar year</li> <li>• Covered at 70%, subject to the deductible</li> <li>• Not covered</li> <li>• Covered at 70%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly</li> <li>• Routine exams not covered</li> </ul>