Rome Area Chamber of Commerce

2010

Health Care Program Choices

Businesses with two or more employees are eligible for Group Rates.
Sole proprietors are also eligible.

Important Message for existing Chamber Members subscribing to the Chamber Group Health Insurance Program

Enclosed are several insurance plans offered in cooperation with the Chamber. Not included in this publication is information on three different High Deductible Health Plans—please contact the Chamber for details.

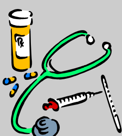
In 2010, January & July Are Open Enrollment Months

Twice a year, in January and July*, existing Chamber Members and their employees have an opportunity to enroll in the Chamber Group Health Insurance Program. Choices of deductibles and other plan options are enclosed. If you are already enrolled in the Chamber Group Health Insurance Program, but would like to switch, for example, from a comprehensive plan to an HMO Plan (or vise versa), the recommended time to change is:

By December 15 for a January 1, 2010 effective date;
or by June 15 for a July 1, 2010 effective date.
*(***Excellus BCBS offers only one open enrollment: January, while MVP and CDPHP offers two: January and July).***

Changes to your health insurance policy are easy to make, providing you follow these important rules:

- A newlywed spouse can be added to the policy the date of the marriage. You must notify the Chamber within 30 days of the marriage.
- A newborn child can be added to the policy as of the date of birth. You must notify the Chamber within 30 days of the birth.
- An existing spouse or existing children can only be added to a health insurance policy twice a year with coverage beginning in January or July. If you wish to add someone to your policy, you must contact the Chamber by December 15 for a January 1, 2010 effective date or by June 15 for a July 1, 2010 effective date.



New Chamber Members interested in subscribing to the Chamber Group Health Care Program are eligible to enroll in the health insurance plan on the first day of the following month that they join the Chamber; call for details.

For insurance related questions, concerns or information, please contact:

Sue Jenks, Account Administrator, (315) 337-1700.

Rome Area Chamber of Commerce, 139 W. Dominick St., Rome, NY 13440-5809
Ph: (315) 337-1700 Fx: (315) 337-1715 Email: sue@romechamber.com Web: www.romechamber.com

The information in this document is a summary prepared by the Chamber and it does not replace the actual contracts issued between subscribers and insurance companies. The Chamber and RACC Services Corp. cannot accept responsibility for omissions or errors.

MVP HEALTH CARE

	Patient Services	MVP $15 EPO	MVP $25 EPO
ROUTINE CARE	CHOICE OF PHYSICIANS	Choice of Physicians/Specialists Must participate with MVP	Choice of Physicians/Specialists Must participate with MVP
	OFFICE VISIT COSTS PRIMARY/SPECIALISTS	$15/Visit	$25/Visit
	ADULT PREVENTIVE CARE PERIODICAL PHYSICALS	Covered in full	Covered in full
	WELL BABY & CHILD CARE	Covered in full	Covered in full
	URGENT CARE	$15/Visit	$25/Visit
HOSPITAL & SURGERY	IN-PATIENT SURGERY	In patient hospitalization Applies - see below	In patient hospitalization Applies - see below
	IN-PATIENT HOSPITALIZATION	$250 First Admission only. Maximum of 3 Copays per family per calendar year.	$500 First Admission only. Maximum of 3 Copays per family per calendar year.
	OUT PATIENT SURGERY	$75/ Visit	$75/ Visit
MATERNITY & WOMEN'S HEALTH	MATERNITY: PHYSICIAN SERVICES NURSERY CARE	Initial diagnostic visit Copay only Covered in full	Initial diagnostic visit Copay only Covered in full
	HOSPITAL SERVICES	Subject to a $250 Copay per person per calendar year. Maximum of 3 Copays per family per calendar year.	Subject to a $500 Copay per person per calendar year. Maximum of 3 Copays per family per calendar year.
	SECOND SURGICAL OPINIONS- NOT REQUIRED/OPTIONAL	Subject to office Copay	Subject to office Copay
	PERIODIC GYNECOLOGICAL EXAMS	Covered in full	Covered in full
	MAMMOGRAPHY SCREENING	$15/Visit	$25/Visit
PRESCRIP-TIONS	PRESCRIPTION COVERAGE	$10/$30/$50 Mail Order 90 Day Supply, 2.5 Copays	$10/$30/$50 Mail Order 90 Day Supply, 2.5 Copays
	LABORATORY SERVICES	Covered in full	Covered in full
EMERGENCY	EMERGENCY ROOM (Worldwide)	$50/Visit when not admitted; if admitted, subject to hospital inpatient Copay.	$50/Visit when not admitted; if admitted, subject to hospital inpatient Copay.
	AMBULANCE	Covered in full	$100 Copay Per Trip
OTHER SERVICES &- REQUIREMENTS	VISION SCREENING/EXAM	Annual Vision Exam $15/Visit	Annual Vision Exam $25/Visit
	CHIROPRACTOR	$15 Copay	$25 Copay
	PHYSICAL/OCCUPATIONAL/SPEECH THERAPY	$15 Copay /per visit Up to 30 visits per calendar year per person	$25 Copay /per visit Up to 30 visits per calendar year per person
	X-RAY & DIAGNOSTIC TESTING	$15 Copay per visit	$25 Copay per visit
	HIGH TECH IMAGING SERVICES (e.g., CT's, MRA's, MRI's, PET SCANS, MRCP's AND CTA's)	$15 Per Procedure	$25 Per Procedure
	MISCELLANEOUS	This is only a summary. Consult plan handbooks for more complete benefit descriptions.	This is only a summary. Consult plan handbooks for more complete benefit descriptions.
	DEPENDANT COVERAGE	Unmarried dependents covered to age 23	Unmarried dependents covered to age 23
	ENROLLMENT REQUIREMENTS	No pre-existing condition clause.	No pre-existing condition clause.
RATES	**QUARTERLY PREMIUMS**	**Individual: $1,834.26 Family: $4,587.75** **Individual SP: $2,096.82 Family SP: $5,263.32**	**Individual: $1,673.61 Family: $4,172.10** **Individual SP: $1,912.08 Family SP: $4,785.30**

MVP HEALTH CARE

Category	Patient Services	MVP Hybrid $25 EPO
ROUTINE CARE	ANNUAL DEDUCTIBLE PER CONTRACT YEAR ANNUAL OUT-OF-POCKET MAXIMUM	$200 per Individual/$500 per Family Some services are subject to satisfaction of the annual deductible. $600 per Individual/$1500 per Family per Contract year.
	COINSURANCE	80%/20% Coinsurance
	OFFICE VISIT COSTS PRIMARY/SPECIALISTS	$25 Copay Per Visit
	ADULT PREVENTIVE CARE PERIODICAL PHYSICALS	Adult Physical/One Routine Adult Physical/Contract Year Covered in Full
	WELL BABY & CHILD CARE	Per MVP Preventive Care Guidelines Covered in Full
HOSPITAL & SURGERY	IN-PATIENT SURGERY	MVP covers at 80% of allowable charges, after deductible
	IN-PATIENT HOSPITALIZATION	MVP covers at 80% of allowable charges, after deductible
	OUT PATIENT SURGERY	MVP covers at 80% of allowable charges, after deductible
MATERNITY & WOMEN'S HEALTH	MATERNITY	Physician Pre/postnatal Care Office Visits– Covered in full– Initial Newborn Exam– Covered in Full
	HOSPITAL SERVICES	Inpatient services (facility/physician)-MVP covers at 80% of allowable charges, after deductible
	OFFICE SURGERY	$25 Copay Per Visit
	PERIODIC GYNECOLOGICAL EXAMS	$25 Copay
	MAMMOGRAPHY SCREENING	Screening Mammography, Pap Tests– Covered in Full
PRESCRIP-TIONS	PRESCRIPTION COVERAGE	$10/$30/$50 Mail Order 90 Day Supply, 2.5 Copays $1000/Member Annual Maximum Benefit
	LABORATORY SERVICES	Outpatient Setting-Covered in Full Inpatient Setting- MVP covers at 80% of allowable charges, after deductible
EMERGENCY	EMERGENCY HOSPITAL CARE	$100 Copay/Per Visit
	AMBULANCE	MVP covers at 80% of allowable charges, after deductible
OTHER SERVICES &- REQUIREMENTS	VISION SCREENING/EXAM	Routine Exam 1 every 2 calendar years $25Copay
	CHIROPRACTOR	$25 Copay/Per Visit
	PHYSICAL THERAPY	(Office Setting) Requires Prescription- 30 Visits/Contract Year $25 Copay Per Visit
	X-RAY & DIAGNOSTIC TESTING	Inpatient Setting-MVP covers at 80% of allowable charges, after deductible Office Setting- $25 Copay office Visit
	HIGH TECH IMAGING SERVICES (e.g., CT's, MRA's, MRI's, PET SCANS, MRCP's AND CTA's)	$25 Copay /Procedure (Office Setting) MVP covers at 80% of allowable charges, after deductible (outpatient Facility)
	MISCELLANEOUS	Please see Benefit Contract
	DEPENDANT COVERAGE	Unmarried dependents covered to age 23
	ENROLLMENT REQUIREMENTS	No pre-existing condition clause.
RATES	QUARTERLY PREMIUMS	**Individual: $1,435.89 Family: $3,570.18** **Individual SP: $1,638.66 Family SP: $4,093.11**

MVP TRIVANTAGE: (CHOOSE ONE)

	Patient Services	Active Lifestyle	Family Focus	Healthy Alternatives
ROUTINE CARE	CHOICE OF PHYSICIANS	Choice of Physicians/Specialists Must participate with MVP	Choice of Physicians/Specialists Must participate with MVP	Choice of Physicians/Specialists Must participate with MVP
	OFFICE VISIT COSTS	Adults $15/Visit, Sick Child Age 5-18 $15/Visit, Birth thru age 4 $15/Visit	Adults $20/Visit, Sick Child Age 5-18 $5/Visit, Birth thru age 4 $0/Visit	Adults $25/Visit, Sick Child Age 5-18 $25/Visit, Birth thru age 4 $25/Visit
	PHYSICALS PREVENTIVE CARE	Covered in full	Covered in full	Covered in full
	WELL CHILD CARE	Covered in full	Covered in full	Covered in full
	IMMUNIZATIONS	Covered in full	Covered in full	Covered in full
HOSPITAL & SURGERY	IN-PATIENT SURGERY	Covered in full	Covered in full	Covered in full
	IN-PATIENT HOSPITALIZATION	Per Continuous Confinement; Adult $300/ Visit; Child thru Age 18 $300/Visit	Per Continuous Confinement; Adult $300/Visit; Child thru Age 18 $0/Visit	Per Continuous Confinement; Adult $300/Visit; Child thru Age 18 $300/Visit
	OUT PATIENT SURGERY	$100/Visit	$100/Visit	$100/Visit
MATERNITY & WOMEN'S HEALTH	PRENATAL & POSTPARTUM PHYSICIAN SERVICES	$200 Per Pregnancy	$0	$200 Per Pregnancy
	NURSERY CARE	Covered in full	Covered in full	Covered in full
	HOSPITAL SERVICES	$500 Per Pregnancy	$0	$500 Per Pregnancy
	SEMI ANNUAL GYN. EXAMS	Covered in full	Covered in full	Covered in full
	MAMMOGRAPHY SCREENING & PAP TEST	Covered in full	Covered in full	Covered in full
PRESCRIP-TIONS	PRESCRIPTION COVERAGE	$10/$30/$50	$10/$30/$50	$10/$30/$50
	Urgent Care	Adults $15/Visit, Sick Child Age 5-18 $15/Visit, Birth thru age 4 $15/Visit	Adults$20/Visit, Sick Child Age 5-18 $5/Visit, Birth thru age 4 $0/Visit	Adults $25/Visit, Sick Child Age 5-18 $25/Visit, Birth thru age 4 $25/Visit
EMERGENCY	EMERGENCY ROOM (Worldwide)	$50/Visit	$75/Visit	$75/Visit
	AMBULANCE	$40 Copay Per Trip	$40 Copay Per Trip	$40 Copay Per Trip
OTHER SERVICES & REQUIREMENTS	VISION SCREENING/EXAM	One Exam per calendar year Adults $15/Visit Child thru Age 18 $20/Visit	One Exam per calendar year Adults $20/Visit Child thru Age 18 $5/Visit	One Exam per calendar year Adults $25/Visit Child thru Age 18 $20/Visit
	CHIROPRACTOR	$15/Visit	$20/Visit	$25/Visit
	PHYSICAL/OCCUPATIONAL/ SPEECH THERAPY	$40/Visit 30 Visits Per Contract Year	$40/Visit 30 Visits Per Contract Year	$40/Visit 30 Visits Per Contract Year
	LAB & X-RAY (Outpatient)	Lab-Covered in full X-Ray $40/Visit	Lab-Covered in full X-Ray $40/Visit	Lab-Covered in full X-Ray $40/Visit
	HIGH TECH IMAGING SERVICES (E.G., CT's, MRA's, MRI's, PET SCANS, MRCP's AND CTA's)	$40/Visit	$40/Visit	$40/Visit
	MISCELLANEOUS	Lifestyle Credits (per subscriber) $300 Credit For: Gym membership, fitness class, skiing & much more.	Lifestyle Credits (per subscriber) $300 Credit For: Kids swim lessons, dance classes, sports camps & much more.	Lifestyle Credits (per subscriber) $300 Credit For: Massage therapy, chiropractic care, & acupuncture.
	DEPENDANT COVERAGE	Unmarried dependents covered to age 23	Unmarried dependents covered to age 23	Unmarried dependents covered to age 23
	ENROLLMENT REQUIREMENTS	No pre-existing condition clause.	No pre-existing condition clause.	No pre-existing condition clause.
RATES	QUARTERLY PREMIUMS	**Individual: $1,658.97 Family: $4,135.11 Ind SP: $1,912.08 Fam SP: $4,785.30**	**Individual: $1,658.97 Family $4,135.11 Ind SP: $1,912.08 Fam SP: $4,785.30**	**Individual: $1,658.97 Family: $4,135.11 Ind SP: $1,912.08 Fam SP: $4,785.30**

CDPHP

	Patient Services	CDPHP $15 Co pay	CDPHP EPO
ROUTINE CARE	CHOICE OF PHYSICIANS	Choice of Physicians/Specialists Now with access throughout total network	PCP not required Referrals not required No coverage out of network
	OFFICE VISIT COSTS	$15 Copay per visit	$25 Copay per visit
	PHYSICALS - PREVENTIVE CARE	$15 Copay per visit Annual Adult exam– covered in full	$25 Copay per visit Annual Adult exam– covered in full
	WELL CHILD CARE	Covered in full	Covered in full
	IMMUNIZATIONS	Covered in full	Covered in full
HOSPITAL & SURGERY	IN-PATIENT SURGERY	Covered in full after $500 Inpatient Copay	Deductible then 20%
	IN-PATIENT HOSPITALIZATION	$500 Copay	Deductible then 20%
	OUT PATIENT SURGERY	$100 CoPay	Deductible then 20%
MATERNITY & WOMEN'S HEALTH	PRENATAL & POSTPARTUM PHYSICIAN SERVICES	Covered in full	Deductible then 20%
	DELIVERY	Covered in full after $500 Inpatient Copay	Deductible then 20%
	HOSPITAL SERVICES	Covered in full after $500 Inpatient Copay	Deductible then 20%
	ROUTINE & NON - ROUTINE GYN. EXAMS	$15 Copay - no referrals necessary	Annual gynecological exam– Covered in full
	MAMMOGRAPHY SCREENING & PAP TEST	Mammography covered in full	Mammography covered in full
PRESCRIP-TIONS	LOCAL	50% generic drug 50% preferred brand name drugs 50% non-preferred brand name drugs	$4.00 generic drug 50% coinsurance brand name drugs
	MAINTENANCE	Prescription by mail order available 50% Co insurance– 90 day supply	Mail order 2.5 Copayments for 90-day supply
EMERGENCY	EMERGENCY ROOM	$75 Copay waived if admitted	Deductible then 20% (coinsurance waived if admitted)
	AMBULANCE (Medical Necessary)	$75 Copay	Deductible then 20%
OTHER SERVICES &- REQUIREMENTS	VISION SCREENING/EXAM	No Coverage	1 routine visit every 24 months subject to deductible & copayment or coinsurance. CDPHP will pay $75 for Frames, Lenses or Contacts once every 24 months
	CHIROPRACTOR	$15 Copay	$25 Copay
	PHYSICAL THERAPY (Out - Patient)	$15 Copay: up to 30 visits for Physical Therapy & Occupational Therapy, 20 visits for Speech	$25 Copay Up to 30 visits per benefit year
	X-RAY & DIAGNOSTIC TESTING	$15 Copay	$25 Copay
	ALLERGY TREATMENTS	$15 Copay tests and treatments	$25 Copay
	MISCELLANEOUS	Consult contract for complete benefit description	Consult contract for complete benefit description
	DEPENDANT COVERAGE	To age 19 Students to age 25	To age 19 Students to age 25
	ENROLLMENT REQUIREMENTS	12 month pre-existing Condition Clause does apply	12 month pre-existing Condition Clause does apply
RATES	**QUARTERLY PREMIUMS**	**Individual: $1,640.85 Family: $4,143.87** **Ind SP: $1,858.80 Family SP: $4,712.88**	**Individual: $1,252.29 Family: $3,130.53** **Ind SP: $1,415.85 Family SP: $3,557.04**

EXCELLUS BC/BS UTICA REGION

Section	Patient Services	HealthyBlue $15/$25	HealthyBlue $25/$40
ROUTINE CARE	CHOICE OF PHYSICIANS	PCP not required Referrals not required Coverage provided worldwide through Blue Card program.	PCP not required Referrals not required Coverage provided worldwide through Blue Card program.
	OFFICE VISIT COSTS	Adults $15 per visit Children to age 19: $0 per visit	Adults $25 per visit Children to age 19: $0 per visit
	PHYSICALS PREVENTIVE CARE	Adult covered in full for up to one exam per calendar year.	Adult covered in full for up to one exam per calendar year.
	WELL CHILD CARE	Covered in Full	Covered in Full
	IMMUNIZATIONS	Covered in Full	Covered in Full
HOSPITAL & SURGERY	IN-PATIENT SURGERY	Covered at 80%, subject to the deductible $500/$1500	Covered at 80%, subject to the deductible $500/$1500
	IN-PATIENT HOSPITALIZATION	Covered at 80%, subject to the deductible $500/$1500	Covered at 80%, subject to the deductible $500/$1500
	OUT PATIENT SURGERY	Covered at 80%, subject to the deductible $500/$1500	Covered at 80%, subject to the deductible $500/$1500
MATERNITY & WOMEN'S HEALTH	PRENATAL & POSTPARTUM PHYSICIAN SERVICES	Covered at 80%, subject to the deductible $500/$1500	Covered at 80%, subject to the deductible $500/$1500
	DELIVERY	Covered at 80%, subject to the deductible $500/$1500	Covered at 80%, subject to the deductible $500/$1500
	HOSPITAL SERVICES	Covered at 80%, subject to the deductible $500/$1500	Covered at 80%, subject to the deductible $500/$1500
	ROUTINE GYN. EXAMS	Covered in Full	Covered in Full
	MAMMOGRAPHY SCREENING & PAP TEST	Covered in Full	Covered in Full
PRESCRIPTIONS	LOCAL	Generic– $5, Preferred drugs– $25, & Non-preferred–$50. $0 generics for kids to age 19.	Generic– $5, Preferred drugs– $25, & Non-preferred–$50. $0 generics for kids to age 19.
	MAINTENANCE	Mail order– 90 day supply for two co-pays is available through PimeMail @ mail order service.	Mail order– 90 day supply for two co-pays is available through PimeMail @ mail order service.
EMERGENCY	EMERGENCY ROOM URGENT CARE CENTER	$150 Copay Waived if admitted as inpatient Freestanding Urgent Care Center $25 Copay per visit	$250 Copay Waived if admitted as inpatient
	AMBULANCE (Medically Necessary)	$150 Copay per emergency	$250 Copay per emergency
OTHER SERVICES & REQUIREMENTS	VISION SCREENING/EXAM	$25 Copay per visit—1 visit per year $60 eyewear allowance per year	$40 Copay per visit—1 visit per year $60 eyewear allowance per year
	CHIROPRACTOR	$25 Copay per visit	$40 Copay per visit
	PHYSICAL THERAPY (Out– Patient)	$25 Copay per visit for up to 45 visits for physical, speech, & occupational therapy combined.	$40 Copay per visit for up to 45 visits for physical, speech, & occupational therapy combined.
	X-RAY & DIAGNOSTIC TESTING	X-rays $25 Copay per visit Lab & pathology covered in full	X-rays $40 Copay per visit Lab & pathology covered in full
	ALLERGY TREATMENTS	PCP Adults: $15 Copay per visit PCP Children to age 19: $0 per visit	PCP Adults: $25 Copay per visit PCP Children to age 19: $0 per visit
	WELLNESS PROGRAM	Healthy Rewards On line incentive	Healthy Rewards $500. On line incentive
RATES	DEPENDANT COVERAGE	Students/Dependents covered to age 26	Students/Dependents covered to age 26
	QUARTERLY PREMIUMS	**Individual: $1,432.77 Individual SP: $1,567.68 Sub & Spouse: $2,781.54 Sub & Spouse SP: $3,051.36 Sub & Child: $2,807.34 Sub & Child SP: $3,079.71 Family: $3,840.81 Family SP: $4,216.59**	**Individual: $1,369.44 Individual SP: $1,497.96 Sub & Spouse: $2,654.88 Sub & Spouse SP: $2,911.92 Sub & Child: $2,678.31 Sub & Child SP: $2,937.69 Family: $3,662.79 Family SP: $4,020.66**

EXCELLUS BC/BS UTICA REGION

	Patient Services	HMO Blue 25	BLUE EPO $20 Co Pay
ROUTINE CARE	CHOICE OF PHYSICIANS	PCP– required Referral– required No coverage out of network	PCP not required Referrals not required No coverage out of network
	OFFICE VISIT COSTS	PCP $25 Specialist $40	$20 Copay per visit
	PHYSICALS PREVENTIVE CARE	$25 Copay	$20 Copay per visit
	WELL CHILD CARE	Covered in Full	Covered in Full– to age 19
	IMMUNIZATIONS	Adult $25 Copay	Covered in Full - to age 19
HOSPITAL & SURGERY	IN-PATIENT SURGERY	20% coinsurance or $200 Copay whichever is less	Covered in Full
	IN-PATIENT HOSPITALIZATION	Covered in full after $250 Copay	Unlimited days of semi-private accommodations and all medically necessary services for acute care- Covered in Full
	OUT PATIENT SURGERY	Facility: covered in full after $75 Copay, Physician: 20% coinsurance or $200 Copay whichever is less	$50 Copay
MATERNITY & WOMEN'S HEALTH	PRENATAL & POSTPARTUM PHYSICIAN SERVICES	$25 Copay first 10 visits Remainder covered in full	Covered in Full
	DELIVERY	Facility: covered in full after $250 Copay, Physician: 20% coinsurance or $200 Copay whichever is less	Covered in Full
	HOSPITAL SERVICES	Hospital inpatient subject to $250 Copayment	Covered in Full
	ROUTINE GYN. EXAMS	Routine - $25 Copay	Covered in Full
	MAMMOGRAPHY SCREENING & PAP TEST	$25 Copay	Covered in Full
PRESCRIP-TIONS	LOCAL	$10 generic drug $25 preferred brand name drugs $40 non-preferred brand name drugs	$10 first tier, $25 second tier, $40 third tier
	MAINTENANCE	30 day supply - 1 Copay, 60 day supply - 2 Copays	30 day supply - 1 copay 60 day supply - 2 copays 90 day supply - 3 copays
EMERGENCY	EMERGENCY ROOM	$100 Copayment (waived if followed by hospitalization within 24 hours)	E.R. $50 Copay if not followed by admission Urgent Care $25 Copay
	AMBULANCE (Medically Necessary)	$100 Copayment	$50 Copay
OTHER SERVICES & REQUIREMENTS	VISION SCREENING/EXAM	$40 Copay Routine eye exam every 2 years Every year for children to a age 19	$20 Copay 1 visit every two years
	CHIROPRACTOR	$40 Copay	$20 Copay
	PHYSICAL THERAPY (Out–Patient)	$40 Copayment up to 30 visits Physical, Speech, Occupational & Respiratory Therapy combined	40 visits - $20 Copay Physical, Speech , Occupational & Respiratory
	X-RAY & DIAGNOSTIC TESTING	$40 Co ayment	$20 Copay
	ALLERGY TREATMENTS	$25 PCP– Copay $40 Specialist Copay	$20 Copay
	MISCELLANEOUS	Consult contract for complete benefit description	Consult contract for complete Benefit description
	DEPENDANT COVERAGE	To age 19-Student to age 23	To age 19-Student to age 23
	ENROLLMENT REQUIREMENTS	11 month pre-existing Condition Clause does apply	11 month pre-existing Condition Clause does apply
RATES	QUARTERLY PREMIUMS	**Individual: $1,583.01 Family: $3,889.92 Individual SP: $1,732.95 Family SP: $4,270.56**	**Individual: $1,758.24 Family: $4,338.90 Individual SP: $1,925.67 Family SP: $4,764.42**

EXCELLUS BC/BS UTICA REGION

Section	Patient Services	Blue Healthy Choices- (Choose One)	
		Fit & Healthy	***Healthy Family***
ROUTINE CARE	CHOICE OF PHYSICIANS	PCP Not Required	PCP Not Required
	OFFICE VISIT COSTS	$20 CoPay	Adults- $25 Copay Kids to 19- $0 Copay
	PHYSICALS - PREVENTIVE CARE	$20 CoPay	$25 CoPay
	WELL CHILD CARE	Covered in Full	Covered in Full
	IMMUNIZATIONS	Adult immunizations $20 Copay	Adult immunizations $25 Copay
HOSPITAL & SURGERY	IN-PATIENT SURGERY	20% coinsurance or $200 Copay whichever is less	20% coinsurance or $200 Copay whichever is less
	IN-PATIENT HOSPITALIZATION	Covered in full after $500 Copay	Covered in full after $500 Copay
	OUT PATIENT SURGERY	Facility: $75 Copay Physician: Covered in full	Facility: $75 Copay Physician: Covered in full
MATERNITY & WOMEN'S HEALTH	PRENATAL & POSTPARTUM PHYSICIAN SERVICES	$20 Copay first 10 visits Remainder covered in full	Covered in full
	DELIVERY	Facility: covered in full after $500 Copay Delivery: 20% coinsurance or $200 Copay whichever is less	Facility: Covered in full Physician: Covered in full
	HOSPITAL SERVICES	Hospital inpatient subject to $500 Copayment	Hospital inpatient subject to $500 Copayment
	ROUTINE GYN. EXAMS	Covered in full	Covered in full
	MAMMOGRAPHY SCREENING & PAP TEST	Covered in full	Covered in full
PRESCRIP-TIONS	LOCAL	$10/$25/$40 with $1000 calendar year maximum per individual	$10/$25/$40 with $1000 calendar year maximum per individual
	MAINTENANCE	90 days supply with separate Copays	90 days supply with separate Copays
EMERGENCY	EMERGENCY ROOM	$100 Copayment per visit Unless admitted within 24 hours	$100 Copayment per visit Unless admitted within 24 hours
	AMBULANCE (Medical Necessary)	$100 Co payment for ground transportation	$100 Co payment for ground transportation
OTHER SERVICES & REQUIREMENTS	VISION SCREENING/EXAM	$20 Copay for one routine eye exam every Year; $20 Copay for children to age 19	$25 Copay for one routine eye exam every year; $0 Copay for children to age 19. $100 eyewear allowance for kids to age 19.
	CHIROPRACTOR	$40 Copay	$40 Copay
	PHYSICAL THERAPY (Out - Patient)	$40 Copayment up to 30 combined Visits Physical, Speech, Occupational Therapy	$40 Copayment up to 30 combined Visits Physical, Speech, Occupational Therapy
	X-RAY & DIAGNOSTIC	$40 Copayment	$40 Copayment
	ALLERGY TREATMENTS	$25 PCP– Copay $40 Specialist Copay	PCP– Adults $25 Co pay; Kids to 19 $0 Copay $40 Specialist Copay
	MISCELLANEOUS	Lifestyle benefits;$300 annual per family toward gym membership, Lasik, teeth whitening, toddler gym & swim & drivers education .	Lifestyle benefits;$100 annual per family toward gym membership, Lasik, teeth whitening, toddler gym & swim programs & drivers education.
	DEPENDANT COVERAGE	Qualified students & dependents to age 19	Qualified students & dependents to age 19
RATES	ENROLLMENT REQUIREMENTS	No pre-existing condition clause if covered by previous insurance at least 11 months	
	QUARTERLY PREMIUMS	**Individual: $1,402.08 Family: $3,366.00** **Individual SP: $1,533.90 Family SP: $3,694.20**	

GUARDIAN DENTALGUARD

IN-NETWORK COVERAGE * (Dentist is a participating Provider with The Guardian)

100% Preventive Services	$50 Per Person Benefit Year Deductible		**50% Orthodontic Services Children to age 19**
	100% Basic Services	**60% Major**	
Teeth Cleaning Fluoride treatments for Children Space maintainers Emergency Treatment Oral Examinations X-Rays Topical Sealants	Laboratory tests Fillings-Amalgam, Silicate, and Acrylic Stainless steel Crowns Diagnostic Casts	Gold and porcelain Installation of bridge work and crowns Periodontic Services Extractions & other Oral Surgery Periodontal Surgery Endontics Root canal Repair and Main. of Bridgework & Dentures	Active Orthodontic Appliances All other orthodontic services
			50% copayment
		40% copayment	$1,500 Lifetime Maximum
$1,000 Per Person Calendar Year Maximum			

OUT-OF-NETWORK COVERAGE

*(Dentist is not participating Provider with The Guardian)

100 %* Preventive Services	$50 Per Person Benefit Year Deductible		**50%* Orthodontic Services Children to age 19**
	80%* Basic Services	**50%* Major Services**	
Teeth Cleaning Fluoride treatments for Children Space maintainers Emergency Treatment Oral Examinations X-Rays Topical Sealants	Laboratory tests Fillings-Amalgam, Silicate, and Acrylic Stainless steel Crowns Diagnostic Casts	Gold and porcelain Installation of bridge work and crowns Periodontic Services Extractions & other Oral Surgery Periodontal Surgery Endontics Root canal Repair and Main. of Bridgework & Dentures	Active Orthodontic Appliances All other orthodontic services
			50% copayment
	20% copayment	50% copayment	$1500 Lifetime Maximum
$1,000 Per Person Calendar Year Maximum			

- Subject to Usual, Reasonable, & Customary. **Quarterly Premiums:** Individual **$191.61** Family **$448.89**
- **Businesses have to have 3 or more employees with 50% participation**.