



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.

In 2012, 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, from your current plan to a different plan the recommended time to change is:

**By December 15 for a January 1, 2012 effective date;
or by June 15 for a July 1, 2012 effective date.**

****(Excellus BCBS offers only one open enrollment: January,
while MVP 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, 2012 effective date or by June 15 for a July 1, 2012 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, Business Manager, (315) 337-1700.

Rome Area Chamber of Commerce, 139 W. Dominick St., Rome, NY 13440-5809

Ph: (315) 337-1700 Fax: (315) 337-1715 Email: sue@romechamber.com Web: www.romechamber.com

MVP HEALTH CARE

	Patient Services	Preferred EPO \$30/\$50	Preferred EPO \$40
ROUTINE CARE	ANNUAL DEDUCTIBLE PER CONTRACT YEAR	\$1,000 per individual/\$2500 per Family Some services are subject to satisfaction of the annual deductible	\$1,000 per individual/\$2,500 per Family Some services are subject to satisfaction of the annual deductible
	ANNUAL OUT-OF-POCKET MAXIMUM	\$3,000 per Individual/\$7,500 per Family per Contract Year	\$3,000 per Individual/\$7,500 per Family per Contract Year
	OFFICE VISIT COSTS PRIMARY/SPECIALISTS	\$30 Copay/Primary Care Provider \$50 Copay/Specialty Care Provider	\$40 Copay/Primary Care Provider \$40 Copay/Specialty Care Provider
	PREVENTIVE COVERED IN FULL	Adult physical-one routine per year, Immunizations, Colonoscopy & Sigmoidoscopy screening for adults, Bone Density Tests & Prostate Cancer Screening	Adult physical-one routine per year, Immunizations, Colonoscopy & Sigmoidoscopy screening for adults, Bone Density Tests & Prostate Cancer Screening
HOSPITAL & SURGERY	WELL BABY & CHILD CARE & IMMUNIZATIONS	Covered in Full	Covered in Full
	URGENT CARE	\$30 Copay	\$40 Copay
	IN-PATIENT SURGERY	80% of allowable charges, after deductible	80% of allowable charges, after deductible
	IN-PATIENT HOSPITALIZATION	80% of allowable charges, after deductible	80% of allowable charges, after deductible
MATERNITY & WOMEN'S HEALTH	OUT PATIENT SURGERY	80% of allowable charges, after deductible	80% of allowable charges, after deductible
	MATERNITY: PHYSICIAN SERVICES NURSERY CARE	Physician Pre/Postnatal Care Office Visits– Covered in full. Inpatient Services (facility/physician) 80% of allowable charges, after deductible. Initial Newborn Exam Covered in full.	Physician Pre/Postnatal Care Office Visits– Covered in full. Inpatient Services (facility/physician) 80% of allowable charges, after deductible. Initial Newborn Exam Covered in full.
	HOSPITAL SERVICES	80% of allowable charges, after deductible	80% of allowable charges, after deductible
	SECOND SURGICAL OPINIONS- NOT REQUIRED/OPTIONAL	\$50 Copay/Specialist	\$40 Copay/Specialist
	YEARLY GYNECOLOGICAL EXAMS	Annual Pap Test & Ob/Gyn Exam Covered in full	Annual Pap Test & Ob/Gyn Exam Covered in full
	MAMMOGRAPHY SCREENING	Covered in full	Covered in full
PRESCRIP- TIONS	PRESCRIPTION DRUGS	\$10/50%/50% Mail Order 90 Day Supply, 2.5 Copays	\$10/\$30/\$50 Mail Order 90 Day Supply, 2.5 Copays
	LABORATORY SERVICES	Inpatient- 80% of allowable charges, after deductible Outpatient setting– Covered in Full	Inpatient- 80% of allowable charges, after deductible Outpatient setting– Covered in Full
EMERGENCY	EMERGENCY ROOM	\$200 Copay/Visit	\$200 Copay/Visit
	AMBULANCE	80% of allowable charges, after deductible	80% of allowable charges, after deductible
	ROUTINE VISION EXAM EYEGLASSES & CONTACT LENSES	\$50 Copay/Visit, once every two calendar years \$100 allowance, once every two calendar years	\$40 Copay/Visit, once every two calendar years \$100 allowance, once every two calendar years
OTHER SERVICES &- REQUIREMENTS	CHIROPRACTOR	\$50 Copay/Visit	\$40 Copay/Visit
	PHYSICAL/OCCUPATIONAL/SPEECH THERAPY	\$50 Copay/Visit Office Setting/30 Visits/Contract Year	\$40 Copay/Visit Office Setting/30 Visits/Contract Year
	DIAGNOSTIC X-RAY IMAGING SERVICES (office setting)	\$30 Copay/PCP \$50 Copay/Specialist	\$40 Copay/PCP \$40 Copay/Specialist
	HIGH TECH IMAGING SERVICES (e.g., CT's, MRA's, MRI's, PET SCANS, MRCP's AND CTA's)	80% of allowable charges, after deductible	80% of allowable charges, after deductible
	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	Dependents to age 26	Dependents to age 26
RATES	ENROLLMENT REQUIREMENTS	No pre-existing condition clause	No pre-existing condition clause
	QUARTERLY PREMIUMS	Individual: \$1,610.01 2-Person: \$3,130.02 Family: \$4,042.02 Individual SP: \$1,838.01 2-Person SP: \$3,586.02 Family SP: \$4,634.82	Individual: \$1,715.85 2-Person: \$3,341.70 Family: \$4,317.21 Individual SP: \$1,959.72 2-Person SP: \$3,829.47 Family SP: \$4,951.32

MVP HEALTH CARE

	Patient Services	MVP HDHP (High Deductible Health Plan) EPO	
ROUTINE CARE	ANNUAL DEDUCTIBLE PER CONTRACT YEAR ANNUAL OUT-OF-POCKET MAXIMUM	\$2,500 per Individual/\$5000 per Family \$5,000 per Individual/\$10,000 per Family per Contract year (includes deductible & prescription drug copayments)	
	COINSURANCE	None for benefits noted below, except DME	
	OFFICE VISIT COSTS PRIMARY/SPECIALISTS	\$30 Copay/Primary Care Provider Office Visit, after deductible \$50 Copay/Specialty Care Provider Office Visit, after deductible	
	ADULT PREVENTIVE CARE PERIODICAL PHYSICALS	Adult Annual Physical/Immunizations/Colonoscopy/Sigmoidoscopy Screening & Bone Density Tests. Covered in Full- Deductible does not apply	
	WELL BABY & CHILD CARE	Well Baby, Child Care & Immunizations Covered in Full	
HOSPITAL & SURGERY	OFFICE SURGERY	\$50 Copay/Specialty Care Provider Office Visit, after deductible	
	IN-PATIENT HOSPITALIZATION	\$500 Copay, after deductible	
	OUT PATIENT SURGERY	\$200 Copay, after deductible	
MATERNITY & WOMEN'S HEALTH	MATERNITY	Physician Pre/postnatal Care Office Visits, Covered in full. Inpatient Services (facility/physician)- \$500 Copay, after deductible. Initial Newborn Exam- Covered in Full	
	PERIODIC GYNECOLOGICAL EXAMS	Pap Tests- Preventive Covered in Full	
	MAMMOGRAPHY SCREENING	Screening Mammography-Preventive Covered in Full	
	PRESCRIPTION DRUGS	\$5/\$35/\$70 Copay after deductible is met	
PRESCRIP-TIONS	LABORATORY SERVICES	Covered in full after deductible	
	URGENT CARE CENTER	\$50 Copay/visit- after deductible	
	EMERGENCY ROOM	\$150 Copay/after deductible	
EMERGENCY	AMBULANCE	\$150 Copay/Trip- after deductible	
	VISION SCREENING/EXAM	\$50 Copay Visit/ after deductible Eyeglasses & Contact Lenses- Once every two years- \$100 allowance after deductible Eyeglasses	
OTHER SERVICES &- REQUIREMENTS	CHIROPRACTOR	\$50 Copay/Per Visit, after deductible	
	PHYSICAL/OCCUPATIONAL & SPEECH THERAPY	(Office Setting) Combined 30 Visits/Contract Year \$50 Copay Per Visit/after deductible	
	X-RAY & DIAGNOSTIC TESTING	\$30 Copay/Primary Care Provider Office Visit, after deductible \$50 Copay/Specialty Care Provider Office Visit, after deductible	
	HIGH TECH IMAGING SERVICES (e.g., CT's, MRA's, MRI's, PET SCANS, MRCP's AND CTA's)	\$50 Copay/Per Procedure, after deductible	
	MISCELLANEOUS	Domestic Partner coverage available	
	DEPENDANT COVERAGE	Dependents covered to age 26	
	ENROLLMENT REQUIREMENTS	No pre-existing condition clause.	
RATES	QUARTERLY PREMIUMS	Individual: \$1,101.03 2-Person: \$2,112.06 Family: \$2,718.66 Individual SP: \$1,252.68 2-Person SP: \$2,415.39 Family SP: \$3,112.98	

MVP HEALTH CARE

	Patient Services	MVP-HDHP (High Deductible Health Plan) EPO
ROUTINE CARE	ANNUAL DEDUCTIBLE PER CONTRACT YEAR	\$1,500 per Individual/\$3,000 per Family
	ANNUAL OUT-OF-POCKET MAXIMUM	\$2,500 per Individual/\$5,000 per Family
	COINSURANCE	MVP covers at 100% of allowable charges
	OFFICE VISIT COSTS PRIMARY/SPECIALISTS	MVP covers at 100% of allowable charges, after deductible
HOSPITAL & SURGERY	ADULT PREVENTIVE CARE	Adult Annual Physical/Immunizations/Colonoscopy/Sigmoidoscopy Screening & Bone Density Tests Covered in Full- Deductible does not apply
	WELL BABY & CHILD CARE	Covered in Full (per schedule)
	IN-PATIENT SURGERY	MVP covers at 100% of allowable charges, after deductible
	IN-PATIENT HOSPITALIZATION	MVP covers at 100% of allowable charges, after deductible
MATERNITY & WOMEN'S HEALTH	OUT PATIENT SURGERY	MVP covers at 100% of allowable charges, after deductible
	MATERNITY	MVP covers at 100% of allowable charges, after deductible
	HOSPITAL SERVICES	MVP covers at 100% of allowable charges, after deductible
	OFFICE SURGERY	MVP covers at 100% of allowable charges, after deductible
PRESCRIPTIONS	PERIODIC GYNECOLOGICAL EXAMS	Covered in Full
	MAMMOGRAPHY SCREENING	Covered in Full
EMERGENCY	PRESCRIPTION DRUGS	\$10/\$30/\$50 Copay after deductible is met
	LABORATORY SERVICES	MVP covers at 100% of allowable charges, after deductible
	EMERGENCY HOSPITAL CARE	MVP covers at 100% of allowable charges, after deductible
OTHER SERVICES & REQUIREMENTS	AMBULANCE	MVP covers at 100% of allowable charges, after deductible
	LIFETIME MAXIMUM BENEFIT PAYABLE	No Maximum
	CHIROPRACTOR	MVP covers at 100% of allowable charges, after deductible
	PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	MVP covers at 100% of allowable charges, after deductible 30 Visits per member per contract year combined
	X-RAY & DIAGNOSTIC TESTING	MVP covers at 100% of allowable charges, after deductible
	HIGH TECH IMAGING SERVICES (e.g., CT's, MRA's, MRI's, PET SCANS, MRCP's AND CTA's)	MVP covers at 100% of allowable charges, after deductible
	MISCELLANEOUS	Please see Benefit Contract
	DEPENDANT COVERAGE	Dependents covered to age 26
	ENROLLMENT REQUIREMENTS	No pre-existing condition clause.
	RATES	QUARTERLY PREMIUMS

MVP TRIVANTAGE: (CHOOSE ONE)

	Patient Services	Active Lifestyle	Family Focus	Healthy Alternatives
ROUTINE CARE HOSPITAL & SURGERY MATERNITY & WOMEN'S HEALTH PRESCRIPTIONS EMERGENCY OTHER SERVICES & REQUIREMENTS RATES	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 Specialists	Adults \$15/Visit, Sick Child Age 5-18 \$15/Visit, Birth thru age 4 \$15/Visit Specialist \$40 Copay	Adults \$20/Visit, Sick Child Age 5-18 \$5/Visit, Birth thru age 4 \$0/Visit Specialist \$40 Copay	Adults \$25/Visit, Sick Child Age 5-18 \$25/Visit, Birth thru age 4 \$25/Visit Specialist \$40 Copay
	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
	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
	PRENATAL & POSTPARTUM PHYSICIAN SERVICES	\$200 Per Pregnancy	\$0 Copay	\$200 Per Pregnancy
	NURSERY CARE	Covered in full	Covered in full	Covered in full
	HOSPITAL SERVICES	\$500 Per Pregnancy	\$0 Copay	\$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
	PRESCRIPTION DRUGS	\$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 ROOM (Worldwide)	\$50/Visit	\$75/Visit	\$75/Visit
	AMBULANCE	\$40 Copay Per Trip	\$40 Copay Per Trip	\$40 Copay Per Trip
	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	Dependents covered to age 26	Dependents covered to age 26	Dependents covered to age 26
	ENROLLMENT REQUIREMENTS	No pre-existing condition clause.	No pre-existing condition clause.	No pre-existing condition clause.
QUARTERLY PREMIUMS	Individual: \$2,033.76 2-Person: \$3,977.52 Family: \$5,143.77 Individual SP: \$2,325.33 2-Person SP: \$4,560.66 Family SP: \$5,901.84	Individual: \$2,033.76 2-Person: \$3,977.52 Family: \$5,143.77 Individual SP: \$2,325.33 2-Person SP: \$4,560.66 Family SP: \$5,901.84	Individual: \$2,033.76 2-Person: \$3,977.52 Family: \$5,143.77 Individual SP: \$2,325.33 2-Person SP: \$4,560.66 Family SP: \$5,901.84	

EXCELLUS BC/BS UTICA REGION

	Patient Services	Simply Blue-PPO Copay
ROUTINE CARE	CHOICE OF PHYSICIANS	PCP- Not Required Referrals-Not Required
	OFFICE VISIT COSTS	PCP-\$15 Copay per visit Children to age 19: \$0 Copay per visit Specialists-\$25 Copay per visit
	PHYSICALS PREVENTIVE CARE	One Routine Adult Physical/Contract Year Covered in Full
	WELL CHILD CARE	Covered in Full
HOSPITAL & SURGERY	IMMUNIZATIONS	Covered in Full
	IN-PATIENT SURGERY	Covered in Full
	IN-PATIENT HOSPITALIZATION	\$250 Copay per admission
	OUT PATIENT SURGERY	\$150 Copay
MATERNITY & WOMEN'S HEALTH	PRENATAL & POSTPARTUM CARE	Covered in Full
	DELIVERY	Covered in Full
	HOSPITAL SERVICES	\$250 Copay per admission
	ROUTINE GYN. EXAMS	Covered in Full
	MAMMOGRAPHY SCREENING & PAP TEST	Covered in Full
PRESCRIP- TIONS	PRESCRIPTION DRUGS	\$5/\$35/\$70 \$0 Copay for generics for children to age 19
	URGENT CARE	\$25 Copay per visit
	EMERGENCY ROOM	\$150 Copay Copay per visit unless admitted within 24 hours
EMERGENCY	AMBULANCE	\$150 Copay
	VISION SCREENING/EXAM	\$25 Copay for one routine exam every year. \$60 eyewear allowance available per year
OTHER SERVICES & REQUIREMENTS	CHIROPRACTOR	\$25 Copay per visit
	PHYSICAL THERAPY (Out-Patient)	\$25 Copay for up to a combined total of 45 visits per year for physical, speech & occupational therapy
	X-RAY & DIAGNOSTIC TESTING	\$25 Copay per visit
	ALLERGY TREATMENTS	Adult: \$15 Copay per visit to your PCP; \$25 Copay per visit to a specialist. Child: \$0 Copay per visit to your PCP; \$25 Copay to a specialist
	MISCELLANEOUS	Deductible In Network: None Deductible Out of Network : \$500 Individual; \$1,500 Family
	DEPENDANT COVERAGE	Dependents to age 26
	ENROLLMENT REQUIREMENTS	No pre-existing condition clause
RATES	QUARTERLY PREMIUMS	Individual: \$1,835.37 Individual SP: \$2,009.91 Sub & Spouse: \$3,580.77 Sub & Spouse SP: \$3,929.85 Sub & Child: \$3,621.15 Sub & Child SP: \$3,974.25 Family: \$4,961.19 Family SP: \$5,448.27

EXCELLUS BC/BS UTICA REGION

	Patient Services	HealthyBlue Copay & Deductible \$15/\$25	HealthyBlue Copay & Deductible \$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	Adult: \$55 Copay per visit PCP/\$25 Copay Per visit Specialist Child: \$0 per visit PCP/\$25 Copay Per visit Specialist	Adult: \$25 Copay per visit PCP/\$40 Copay Per visit Specialist Child: \$0 per visit PCP/\$40 Copay Per visit Specialist	
	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 PHYSI- CIAN 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	
PRESCRIP- TIONS	PRESCRIPTION DRUGS	Generic- \$5, Preferred drugs- \$35, & Non-preferred-\$70. \$0 generics for kids to age 19.	Generic- \$5, Preferred drugs- \$35, & Non-preferred-\$70. \$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 Urgent Care \$40 Copay	
	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	
	DEPENDANT COVERAGE	Dependents covered to age 26	Dependents covered to age 26	
	RATES	QUARTERLY PREMIUMS	Individual: \$1,734.45 Individual SP: \$1,898.94 Sub & Spouse: \$3,379.05 Sub & Spouse SP: \$3,707.94 Sub & Children: \$3,413.40 Sub & Children SP: \$3,745.77 Family: \$4,674.66 Family SP: \$5,133.12	Individual: \$1,662.57 Individual SP: \$1,819.86 Sub & Spouse: \$3,235.23 Sub & Spouse SP: \$3,549.75 Sub & Children: \$3,266.97 Sub & Children SP: \$3,584.67 Family: \$4,472.58 Family SP: \$4,910.85

EXCELLUS BC/BS UTICA REGION

ROUTINE CARE	Patient Services	Simply Blue HDHP	Simply Blue Copay & Deductible PPO
		ANNUAL DEDUCTIBLE PER CONTRACT YEAR	\$5,500 per individual/\$11,000 Family
	ANNUAL OUT-OF-POCKET MAXIMUM	Combined in and out of network \$5,500 per individual/\$11,000 Family	Combined in and out of network \$3000 Individual / \$9000 Family
	OFFICE VISIT COSTS	Covered at 100%, subject to the deductible	Primary Care Physician \$40 Copay per visit, Children to age of 19 \$0 Copay per visit. Specialists \$60 Copay 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 VISITS	Covered in Full	Covered in Full
HOSPITAL & SURGERY	IMMUNIZATIONS	Covered in Full	Covered in Full
	IN-PATIENT SURGERY	Covered at 100%, subject to the deductible	Covered at 80%, subject to the deductible \$1000 individual / \$3000 Family
	IN-PATIENT HOSPITALIZATION	Covered at 100%, subject to the deductible	Covered at 80%, subject to the deductible \$1000 individual / \$3000 Family
	OUT PATIENT SURGERY	Covered at 100%, subject to the deductible	Covered at 80%, subject to the deductible \$1000 individual / \$3000 Family
MATERNITY & WOMEN'S HEALTH	PRENATAL & POSTPARTUM PHYSICIAN SERVICES	Covered at 100%, subject to the deductible	Covered at 80%, subject to the deductible \$1000 individual / \$3000 Family
	DELIVERY	Covered at 100%, subject to the deductible	Newborn Nursery Care Covered in full
	HOSPITAL SERVICES	Covered at 100%, subject to the deductible	Covered at 80%, subject to the deductible \$1000 individual / \$3000 Family
	ROUTINE GYN. EXAMS	Covered in Full	Covered in Full
PRESCRIPTIONS	MAMMOGRAPHY SCREENING & PAP TEST	Covered in Full	Covered in Full
	PRESCRIPTION DRUGS	Covered at 100%, subject to the plan deductible	\$5/\$35/\$70; \$0 generics for kids to age 19.
EMERGENCY	COLONOSCOPY PROSTATE CANCER SCREENING	Preventive screening Covered in Full	Covered in full
	EMERGENCY ROOM URGENT CARE CENTER	Covered at 100%, subject to the deductible	\$350 Copay Waived if admitted as inpatient within 24 hours Urgent care \$60 Copay per visit
	AMBULANCE (Medically Necessary)	Covered at 100%, subject to the deductible	\$350 Copay
OTHER SERVICES & REQUIREMENTS	VISION SCREENING/EXAM	Covered at 100%, subject to the deductible for one routine exam per year	\$60 Copay for 1 routine exam every year \$60 eyewear allowance per year
	CHIROPRACTOR	Covered at 100%, subject to the deductible	\$60 Copay per visit
	PHYSICAL THERAPY (Out-Patient)	Covered at 100%, subject to the deductible for a combined total of 45 visits per year for physical, speech, & occupational therapy	\$60 Copay pay for up to a combined total of 45 visits per year for physical, speech, & occupational therapy
	X-RAY & DIAGNOSTIC TESTING	Covered at 100%, subject to the deductible	X-rays \$60 Copay per visit Lab & pathology covered in full
	ALLERGY TREATMENTS	Covered at 100%, subject to the deductible	PCP Adults: \$40 Copay per visit, \$60 copay to specialist PCP Children to age 19: \$0 per visit, \$60 copay to specialist
	WELLNESS PROGRAM	Blue365- Exclusive access to information, discounts & Savings	Blue365- Exclusive access to information, discounts & Savings
	DEPENDANT COVERAGE	Dependents covered to age 26	Dependents covered to age 26
RATES	QUARTERLY PREMIUMS	Individual: \$751.44 Individual SP: \$817.59 Sub & Spouse: \$1,412.94 Sub & Spouse SP: \$1,545.24 Sub & Children: \$1,438.74 Sub & Children SP: \$1,573.62 Family: \$1,950.57 Family SP: \$2,136.63	Individual: \$1,480.80 Individual SP: \$1,619.91 Sub & Spouse: \$2,871.63 Sub & Spouse SP: \$3,149.76 Sub & Children: \$2,898.69 Sub & Children SP: \$3,179.58 Family: \$3,964.56 Family SP: \$4,351.98

EXCELLUS BC/BS UTICA REGION

ROUTINE CARE	Patient Services	HDHP-Deductible \$2,600 Individual/\$5,200 Family Out of pocket maximum \$5,500 Individual/\$11,000 Family
	CHOICE OF PHYSICIANS	PCP Not Required
	OFFICE VISIT COSTS	Covered at 100%, subject to deductible
	PREVENTIVE HEALTH CARE	Covered in Full
	WELL CHILD CARE	Covered in Full
	IMMUNIZATIONS	Covered in Full
HOSPITAL &	IN-PATIENT SURGERY	Covered at 100%, subject to deductible
	IN-PATIENT HOSPITALIZATION	Covered at 100%, subject to deductible
	OUT PATIENT SURGERY	Covered at 100%, subject to deductible
	PRENATAL & POSTPARTUM PHYSICIAN SERVICES	Covered at 100%, subject to deductible
MATERNITY &	DELIVERY	Covered at 100%, subject to deductible
	HOSPITAL SERVICES	Covered at 100%, subject to deductible
	ROUTINE GYN. EXAMS	Covered in Full
	MAMMOGRAPHY SCREENING & PAP TEST	Covered in Full
PRESCRIP-	PRESCRIPTION DRUGS	\$5/\$35/\$70; \$0 Copay for generics for children to age 19, subject to deductible
	EMERGENCY ROOM	Covered at 100%, subject to deductible
EMERGENCY	AMBULANCE	Covered at 100%, subject to deductible
	VISION SCREENING/EXAM	Covered at 100%, subject to deductible, for one routine hearing exam per year
OTHER SERVICES	CHIROPRACTOR	Covered at 100%, subject to deductible
	PHYSICAL THERAPY (Out - Patient)	Covered at 100%, subject to deductible for a combined total of 45 visits per year for physical, speech and occupational therapy
	X-RAY & DIAGNOSTIC	Covered at 100%, subject to deductible
	ALLERGY TREATMENTS	Covered at 100%, subject to deductible
	MISCELLANEOUS	Earn cash back with Healthy Rewards. You can earn up to \$500, individually, or a combined \$1,000, cash back for you and an eligible adult member just for doing healthy stuff that fits into your day. Then get paid anytime throughout the year.
	DEPENDANT COVERAGE	Dependents covered to age 26
	ENROLLMENT REQUIREMENTS	No pre-existing condition clause
	QUARTERLY PREMIUMS	Individual: \$1,063.80 Individual SP: \$1,161.18 Sub & Spouse: \$1,969.53 Sub & Spouse SP: \$2,232.48 Sub & Child: \$1,969.53 Sub & Child SP: \$2,272.14 Family: \$2,714.67 Family SP: \$3,100.23

GUARDIAN DENTALGUARD

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

100% Preventive Services Teeth Cleaning Fluoride treatments for Children Space maintainers Emergency Treatment Oral Examinations X-Rays Topical Sealants	\$50 Per Person Benefit Year Deductible		50% Orthodontic Services Children to age 19 Active Orthodontic Appliances All other orthodontic services
	100% Basic Services Laboratory tests Fillings- Amalgam, Silicate, and Acrylic Stainless steel Crowns Diagnostic Casts	60% Major Gold and porcelain Installation of bridge work and crowns Periodontal Services Extractions & other Oral Surgery Periodontal Surgery Endontics Root canal Repair and Main. of Bridgework & Dentures	
		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 Teeth Cleaning Fluoride treatments for Children Space maintainers Emergency Treatment Oral Examinations X-Rays Topical Sealants	\$50 Per Person Benefit Year Deductible		50%* Orthodontic Services Children to age 19 Active Orthodontic Appliances All other orthodontic services
	80%* Basic Services Laboratory tests Fillings- Amalgam, Silicate, and Acrylic Stainless steel Crowns Diagnostic Casts	50%* Major Services Gold and porcelain Installation of bridge work and crowns Periodontal Services Extractions & other Oral Surgery Periodontal Surgery Endontics Root canal Repair and Main. of Bridgework & Dentures	
		20% copayment	\$1500 Lifetime Maximum
\$1,000 Per Person Calendar Year Maximum			

- Subject to Usual, Reasonable, & Customary. **Quarterly Premiums:** Individual **\$ 209.55** Family **\$487.80**
 - **Businesses have to have 3 or more employees with 50% participation.**