2010 BCBS of Western New York New Product Offerings for Cuba Chamber

Services	BCBS of Western New York POS 7100 HSA compatible	Community Blue 206 HMO	Community Blue 206 HMO Plus Pick your copays ($10/$40 or $20/$30)
Deductible **Coinsurance** **Out of Pocket Max.**	**$1,500 Single/$3,000 Family** **N/A** **$5,000 Single/$10,000 Family**	**N/A** **N/A** **N/A**	**N/A** **N/A** **N/A**
Referrals	Not Required	Not Required	Not Required
Office Visits	Covered in Full after Deductible Covered in Full after Deductible	$25 PCP $25 Specialist	$10 or $20 PCP $40 or $30 Specialist
GYN Routine Exams	Covered in Full	$25 Copay	$10 or $20 Copay
Adult Physicals	Covered in Full	$25 Copay	$10 or $20 Copay
Well Child Visits	Covered in Full	Covered in full to age 19	Covered in full to age 19
Sick Child Visits	Covered in Full after Deductible	Covered in full to age 19	Covered in full to age 19
X-rays	Covered in Full after Deductible	$25 Copay	$40 or $30 Copay
Mammograms	Covered in Full	Covered in Full	Covered in Full
Laboratory	Covered in Full after Deductible	Covered in Full	Covered in Full
Hospital Inpatient	Covered in Full after Deductible	$250 Copay	$250 Copay
Maternity Care	Prenatal: Covered in Full after Deductible Delivery: Covered in Full after Deductible Hospital: Covered in Full after Deductible	Prenatal: CIF after initial visit Copay Delivery: $0 Copay Hospital: $0 Copay	Prenatal: CIF after initial visit Copay Delivery: $0 Copay Hospital: $0 Copay
Mental Health **Inpatient: 30 day max** **Outpatient: 20 visits**	 Covered in Full after Deductible Covered in Full after Deductible	 $250 Copay $25 Copay	 $250 Copay $40 or $30 Copay
Outpatient Surgery	Covered in Full after Deductible	$75 Copay	$75 Copay
Emergency Room	Covered in Full after Deductible	$100 Copay	$100 Copay
Routine Eye Exams	Covered in Full after Deductible	$25 Copay	$30 Copay
Eyeware	Discounts available	Discounts available	Discounts available
Acupuncture	Not Covered	Not Covered	Not Covered
Chiropractic	Covered in Full after Deductible	$15 Copay	$15 Copay
Durable Medical Equipment	Covered in Full after Deductible ($1,000 max)	50% Copay ($1,000 annual max)	50% Copay ($1,000 annual max)
External Prosthetics	Covered in Full after Deductible ($1,000 max)	50% Copay ($1,000 annual max)	50% Copay ($1,000 annual max)
Diabetic Supplies/ **Insulin/Oral Agents**	$0 copay after Deductible	$25 Copay	$10 or $20 Copay
Prescription Drug **Mail Order Mandatory**	Deductible must be met, then: Tier 1/$15 Copay Tier 2/$50 Copay Tier 3/50% Copay Mail Order: 2.5 copays for 90 day supply	Copay per 30 day supply Tier 1/$15 Tier 2/$50 Tier 3/50% Mail order: 2.5 copays for 90 day supply	Copay per 30 day supply Tier 1/$15 Tier 2/$50 Tier 3/50% Mail order: 2.5 copays for 90 day supply
Out of Network **Benefit**	Deductible: $1,500 Single/$3,000 Family 30% Coinsurance OOP: $10,000/$20,000 Lifetime Max: Unlimited	Not available	$1,000/$2,000 Annual Ded. 30% Coinsurance
Dependent Coverage	Age 19 (Students to 25)	Age 19 (Students to 25)	Age 19 (Students to 25)
Rates **Single** **Family**	 **$275.27** **$746.77**	 **$452.24** **$1,238.91**	 **$452.24** **$1,238.91**

This comparison is a summary of benefits. This is NOT a contract.