

2010 BCBS of WNY 'Frozen' Plans for the East Aurora Chamber of Commerce

These plans are only available to groups that currently have these plans in their portfolio.

	HMO 104 Plus	POS 150D	Traditional Blue 901
Deductible	N/A	\$500 Single/\$1,000 Family	\$250 Single/\$500 Family
Coinsurance	N/A	20%	20%
Out of Pocket Max	N/A	\$2,000 Single/\$4,000 Family	\$500 Single/\$1,000 Family
Referrals	None	None	None
Office Visits	\$25 PCP \$40 Specialist	\$25 PCP \$40 Specialist	PCP: Deductible and Coinsurance Specialist: Deductible and Coinsurance
Well Child Visits	Covered in Full	Covered in Full	Covered In Full
Sick Child Visits	\$25 Copay	\$25 Copay	Deductible and Coinsurance
GYN Routine Exams	\$25 Copay	\$25 Copay	Covered In Full
Routine Mammograms	Covered in Full	Covered in Full	Covered In Full
Laboratory	Covered in Full	Deductible and Coinsurance	First \$100 is Covered in Full, then Subject to the Deductible and Coinsurance
X-rays	\$40 Copay	Deductible and Coinsurance	Covered In Full
Hospital Inpatient	\$250 Per Admission	Deductible and Coinsurance	\$250 Deductible per confinement
Maternity Care	Prenatal/Post-natal: CIF after initial visit copay Inpatient maternity care: Covered in Full	Prenatal/Post-natal: \$25 Copay Inpatient maternity care: Deductible and Coinsurance	Prenatal/Post-natal: CIF after initial visit copy Inpatient maternity care: Covered in Full
Mental Health			
Inpatient	\$250 Per Admission (30 Day Max)	Deductible and Coinsurance (30 Day Max)	\$250 Deductible per confinement (30 Day Max)
Outpatient	\$40 Copay (20 Visits)	\$40 Copay (20 Visits)	Covered in Full (40 Visits)
Outpatient Surgery	\$75 Copay	Deductible and Coinsurance	Covered In Full
Emergency Room	\$100 Copay	\$100 Copay After Deductible	Covered In Full
Routine Eye Exams	\$30 Copay	\$30 Copay	Not Covered
Eye Wear	Discounts available	Discounts available	Not Covered
Acupuncture	Not Covered	Not Covered	Not Covered
Chiropractic	\$40 Copay	\$40 Copay	Deductible and Coinsurance
Durable Medical Equipment	50% Coinsurance \$1,000 Annual Max	50% Coinsurance After Deductible \$1,000 Annual Max	Deductible and Coinsurance
External Prosthetics	50% Coinsurance \$1,000 Annual Max	50% Coinsurance After Deductible \$1,000 Annual Max	Deductible and Coinsurance
Diabetic Supplies	\$25 Copay	\$25 Copay	Deductible and Coinsurance
Insulin/Oral Agents	\$25 Copay	\$25 Copay	Deductible and Coinsurance
Prescription Drug	<u>Copay per 30 day supply</u> Tier 1/\$15 Tier 2/\$50 Tier 3/50% Mail Order Mandatory for Maintenance Drugs	<u>Copay per 30 day supply</u> Tier 1/\$15 Tier 2/\$50 Tier 3/50% Mail Order: 2.5 copays for 90 day supply	<u>Copay per 30 day supply</u> Prescriptions are subject to the deductible and coinsurance
Out of Network Benefit See full benefit summary for annual/lifetime max	Deductible: \$1,000 Single/\$2,000 Family Coinsurance: 30% OOP: \$5,000/\$10,000	Deductible: \$1,000 Single/\$2,000 Family Coinsurance: 40% OOP: \$5,000/\$10,000	N/A
Dependent Coverage	Age 19 / Students 25	Age 19 / Students 25	Age 19
Rates			
Single	\$364.08	\$270.61	\$856.51
Family	\$993.43	\$734.87	\$1,838.48

The benefit summary is a brief summary of benefits. It is **NOT** a contract.