

2010 BCBS of WNY Benefit Comparison for the East Aurora Chamber of Commerce

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	\$1,500 Single/\$3,000 Family	N/A	N/A
Coinsurance	N/A	N/A	N/A
Out of Pocket Max.	\$5,000 Single/\$10,000 Family	N/A	N/A
Referrals	Not Required	Not Required	Not Required
Office Visits	PCP: \$0 copay after deductible Specialist: \$0 copay 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	\$0 copay after deductible	\$25 Copay	\$10 or \$20 Copay
X-rays	\$0 copay after deductible	\$25 Copay	\$40 or \$30 Copay
Mammograms	Covered in Full	Covered in Full	Covered in Full
Laboratory	\$0 copay after deductible	Covered in Full	Covered in Full
Hospital Inpatient	\$0 copay after deductible	\$250 Copay	\$250 Copay
Maternity Care	Prenatal: \$0 copay after deductible Delivery: \$0 copay after deductible Hospital: \$0 copay 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	\$0 copay after deductible	\$250 Copay	\$250 Copay
Outpatient: 20 visits	\$0 copay after deductible	\$25 Copay	\$40 or \$30 Copay
Outpatient Surgery	\$0 copay after deductible	\$150 Copay	\$150 Copay
Emergency Room	\$0 copay after deductible	\$100 Copay	\$100 Copay
Routine Eye Exams	Covered in Full	\$25 Copay	\$30 Copay
Eye Wear	Discounts available	Discounts available	Discounts available
Acupuncture	Not Covered	Not Covered	Not Covered
Chiropractic	\$0 copay after deductible	\$25 Copay	\$40 or \$30 Copay
Durable Medical Equipment	\$0 copay after deductible (\$1,000 max)	50% Copay (\$1,000 annual max)	50% Copay (\$1,000 annual max)
External Prosthetics	\$0 copay 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	<u>Copay per 30 day supply (after deductible)</u>	<u>Copay per 30 day supply</u>	<u>Copay per 30 day supply</u>
Mail Order Mandatory for Maintenance	Tier 1/\$15 Copay Tier 2/\$50 Copay Tier 3/50% Copay Mail Order: 2.5 copays for 90 day supply	Tier 1/\$15 Tier 2/\$50 Tier 3/50% Mail order: 2.5 copays for 90 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/\$3000 Family Coinsurance: 30% OOP: \$10,000/\$20,000	Deductible: \$1,000 Single/\$2,000 Family 30% Coinsurance OOP Max. \$5000 Single/\$10,000 Family	Deductible: \$1,000 Single/\$2,000 Family 30% Coinsurance OOP Max. \$5000 Single/\$10,000 Family
Dependent Coverage	Age 19 (Students to 25)	Age 19 (Students to 25)	Age 19 (Students to 25)
Rates			
Single	\$275.27	\$452.24	\$452.24
Family	\$746.77	\$1,238.91	\$1,238.91