

GRAND ISLAND CHAMBER OF COMMERCE
2011 HEALTH INSURANCE RATES

	BCBS	BCBS
	2011 - POS7100 PLAN 2	2011 POS 250d SELECT
PHYSICIAN & OTHER SERVICES		
Primary Care Visits-Adult	DEDUCTIBLE + \$25.00	\$25
Routine Physical	COVERED IN FULL	COVERED IN FULL
Specialist Copay-Adult	DEDUCTIBLE + \$25.00	\$40
Allergy Testing & Treatment	DEDUCTIBLE + \$25.00	\$40
Well Child Visit	COVERED IN FULL	COVERED IN FULL
PREVENTATIVE SERVICES		
Colonoscopy		
Mammogram	COVERED IN FULL	COVERED IN FULL
Pap Smear	COVERED IN FULL	COVERED IN FULL
HOSPITAL SERVICES		
Inpatient Hospital	DEDUCTIBLE + \$500.00	20% after deductible
Inpatient Hospice		
Outpatient Hospital	DEDUCTIBLE + \$75.00	20%
Outpatient Procedure-Physicians Office		
Skilled Nursing Facility	DEDUCTIBLE + \$500.00	20% after deductible
MATERNITY SERVICES		
Maternity Services	DEDUCTIBLE + \$25.00	\$25 (applies to first visit only)
In Patient Maternity	DEDUCTIBLE + \$500.00	20% after deductible
EMERGENCY & URGENT CARE		
Emergency Room	DEDUCTIBLE + \$50.00	20% after deductible
Participating After Hour Clinics		
Ambulance	DEDUCTIBLE + \$50.00	20% after deductible
MENTAL HEALTH/SUBSTANCE ABUSE		
Mental Health Inpatient	DEDUCTIBLE + \$500.00	20% after deductible
Mental Health Outpatient	DEDUCTIBLE + \$25.00	\$40 (20 visits per year)
DIABETIC SUPPLIES & SERVICES		
Diabetic Medical Supplies	DEDUCTIBLE + \$25.00	\$25
Diabetic Equipment	50%	50%
REHABILITATION SERVICES		
Chiropractic	DEDUCTIBLE + \$25.00	\$40
DIAGNOSTIC TESTING SERVICES		
Lab Services	DEDUCTIBLE + \$25.00	20%
EKG		
Routine Radiology	DEDUCTIBLE + \$25.00	\$0
MRI	DEDUCTIBLE + \$25.00	20%
Chemotherapy	DEDUCTIBLE + \$25.00	20%
ADDITIONAL SERVICES		
Durable Medical Equipment	DEDUCTIBLE + 50%	50%
VISION SERVICES		
Routine Eye once every 2 yrs	COVERED IN FULL	COVERED IN FULL
Standard Plastic Lenses		
Eyewear-Frames		
Conventional Contact Lenses		
Lasik Eye Surgery		
DEPENDENT COVERAGE		
Dependent Rider	26/26	26/26
Domestic Partner	not covered	not covered
Out-of-Network		
Deductible	\$1500/\$3000	\$2000/\$4000
Coinsurance	70%/30%	50%/50%
Out-of-Pocket Max	\$10000/\$20000	\$10000/\$20000
In-Network:		
Deductible	\$1500/\$3000	\$1000/\$2000
Coinsurance	none	none
PRESCRIPTION DRUG COVERAGES		
Prescription Drug	\$15/\$50/50%	\$15/\$50/50%
Mailorder RX	2.5 copays per 90 day supply	2.5 copays per 90 day supply
Contraceptive Coverage	\$0 copay for generic	\$0 copay for generic
Medicare Part D Credible Coverage status		
Single	<u>\$257.22</u>	<u>\$248.15</u>
Family	<u>\$724.55</u>	<u>\$692.06</u>

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Independent Health Flexfit Select ACTIVE	Independent Health Flexfit Select FAMILY	Univera ValuCare 46 (PPO)	Univera ValuCare 64 (HDHP)
Adult \$15/ Child \$30 \$0	Adult \$25/ Child \$0 \$0	Adult \$30/Child to 19 \$0 \$0	80% after deductible \$0
Adult \$45/ Child \$45 Adult \$15/ Child \$30	Adult \$45/ Child \$45 Adult \$25/ Child \$0	\$50 Adult \$30/Child to 19 \$0	80% after deductible 80% after deductible
\$0	\$0	Allergy Specialist \$50 \$0	\$0
\$0	\$0	\$0 preventive screening	\$0 preventive screening
\$0	\$0	\$0	\$0
\$0	\$0	\$0	\$0
\$750 \$0 \$150	Adult \$750/ Child \$0 \$0 \$150	\$500 \$0 \$0	80% after deductible 80% after deductible 80% after deductible
Adult \$15/Child \$30 \$500	Adult \$25/ Child \$0 Adult \$500/ Child \$0	\$500	80% after deductible 80% after deductible
Adult \$15/ Child \$30 \$750	Adult \$25/ Child \$0 \$0	\$0 \$0	80% after deductible 80% after deductible
\$150 \$45 \$150	\$150 \$45 \$150	\$250 \$50 \$250	80% after deductible 80% after deductible 80% after deductible
\$750 Adult \$15/Child \$25	Adult \$750/ Child \$0 Adult \$25/ Child \$0	\$500 \$50	80% after deductible 80% after deductible
\$15 \$15	\$25 \$25	\$30 \$30	80% after deductible 80% after deductible
\$45	\$45	\$50	80% after deductible
\$0 Adult \$15/ Child \$30	\$0 Adult \$25/ Child \$0	\$0	80% after deductible
\$45 \$45 \$45	\$45 \$45 \$45	\$50 \$50 \$30	80% after deductible 80% after deductible 80% after deductible
		50%	80% after deductible
\$45 Single \$50/BiFocal \$70 40% discount 15% discount 50%	\$45 Single \$50/BiFocal \$70 40% discount 15% discount 50%	50% \$60 allowance	80% after deductible
26/26	26/26	19 covered	26 covered
\$1500/\$3000 30%	\$1000/\$2000 30%	\$500/\$1500 80%	\$1300/\$2600 60%
\$5000/\$10000	\$5000/\$10000	\$1500/\$4500	none
		\$0 100%	\$1300/\$2600 80%
\$10/100%/100%	\$10/100%/100%	\$5/\$45/\$90	\$5/\$35/\$70
2.5 copays for 3 month supply \$0 copay for tier 1 non credible	2.5 copays for 3 month supply \$0 copay for tier 1 non credible	children \$0 generic up to 19	children \$0 generic up to 19 after deductible
<u>\$458.94</u> <u>\$1,147.36</u>	<u>\$458.94</u> <u>\$1,147.36</u>	<u>443.55/SOLE PROP. \$510.09</u> <u>1169.55/SOLE PROP \$1344.98</u>	<u>226.2/SOLE PROP \$306.13</u> <u>706.11/SOLE PROP \$812.03</u>