

Grand Island Chamber of Commerce - Medical Insurance Options for 2010

	Blue Cross & Blue Shield	Blue Cross & Blue Shield HMO 206/ 206 Plus			Community Blue	Independent Health Flex Fit Select <i>choose a lifestyle</i>			Univera Healthcare
	POS 7100	HMO 206	206 Plus A	206 Plus B	~ HMO 104 Plus ~	Active	Family	Independent	Simply
Primary Care Visits	\$0 copay after deductible ★	\$25 ♥	\$10 ♥	\$20 ♥	\$25	\$15 (\$25 for 0 - 18)	\$25 ♥	\$25	\$30 ★
Specialist Services	\$0 copay after deductible	\$25	\$40	\$30	\$40	\$40	\$40	\$40	\$50
In Patient Hospital	\$0 copay after deductible	\$250/\$500	\$250/\$500	\$250/\$500	\$500	\$500	\$500 ♥	\$500	\$500
Out Patient Facility	\$0 copay after deductible	\$75	\$75	\$75	\$75	\$75	\$75	\$75	\$75
Sick Child Care	\$0 copay after deductible	Covered in Full	Covered in Full	Covered in Full	\$0	\$25PCP/\$40Specialist	\$25 ♥	\$25	\$30
Routine Physical-Adult	Covered in Full	\$25	\$10	\$20	\$25	\$0	\$0	\$0	\$30
Mammogram	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	\$0	\$0	\$0	\$30
Emergency Room	\$0 copay after deductible	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100
Ambulance	\$0 copay after deductible	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100
Mental Health Out Pt	\$0 copay after deductible	\$25	\$40	\$30	\$40	\$40	\$40	\$40	\$50 – 20 visits
Chiropractic	\$0 copay after deductible	\$15	\$15	\$15	\$40	\$25	\$25	\$25	\$30
Lab Services	\$0 copay after deductible	Covered in Full	Covered in Full	Covered in Full	\$0	\$0	\$0	\$0	\$0
Radiology	\$0 copay after deductible	\$25	\$40	\$30	\$40	\$40	\$40	\$40	\$30
Durable Medical Equip	\$0 copay after deductible (\$1,000 annual max)	50% to \$1000/yr	50% to \$1000/yr	50% to \$1000/yr	50% to \$1000/yr	50% co-pay	50% co-pay	50% co-pay	50% to \$1,000/yr
Routine Eye Exam	\$0 copay after deductible	\$30	\$25	\$30	\$30 every 2yrs	\$10	\$5	\$20	\$50
Eyewear	discounts	discounts	discounts	discounts	Co-pay for lenses & discounts	Co-pay for lenses & discounts	Co-pay for lenses & discounts	Co-pay for lenses & discounts	VSP Discounts
Lasik Eye Surgery	n/a	n/a	n/a	n/a	50% to \$400/eye	50% discount	50% discount	50% discount	n/a
Dependent Age	19/25 ft student	19/25 ft student	19/ 25 ft student	19/ 25 ft student	19/ 25 ft student	19	23	26	19/ 23 ft student
Out of Network Benefits									
Deductible	\$1,500/ \$3,000	None	\$1000/\$2000	\$1000/\$2000	\$1000/\$2000	\$1000/\$2000	\$1000/\$2000	\$1000/\$2000	None
Co-insurance	30%		70%/30%	70%/30%	70%/30%	70%/30%	70%/30%	70%/30%	
Out of Pocket	\$10,000/ \$20,000		\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000	\$5,000/\$10,000	\$5000/\$10000	\$5000/\$10000	
Annual max /lifetime max	Unlimited	Unlimited	Unlimited	Unlimited	\$100k / \$1 million	None	None	None	
Comments	In Network Deductible same as Out of Network Benefits with out of pocket at \$5,000/\$10,000.	Pharmacy restrictions SEE PLAN BOOK FOR MORE DETAILS	Pharmacy restrictions SEE PLAN BOOK FOR MORE DETAILS	Pharmacy restrictions SEE PLAN BOOK FOR MORE DETAILS	Pharmacy restrictions SEE PLAN BOOK FOR MORE DETAILS	\$250 per subscriber towards a health club membership at participating locations	\$250 toward health club membership or Family Fitness Programs	\$250 toward Alternative Therapies, or vitamins	★\$0 copay for child well-visits to age 18
Prescription Drug	\$15//50/50% only after deductible	\$15/\$50/ 50% with mail order mandatory	\$15/\$50/ 50% with mail order mandatory	\$15/\$50/ 50% with mail order mandatory	\$15/\$50/ 50% with mail order mandatory	\$10 generic only	\$10 generic only	\$10 generic only	\$7 / \$50 / \$100 \$1,000 annual maximum on brand names. Maintenance drugs require mail order pharmacy
Oral Contraceptives	Co-pay	\$0 Generic	\$0 Generic	\$0 Generic	\$0 Generic	\$0 co-pay tier 1 only	\$0 co-pay tier 1 only	\$0 co-pay tier 1 only	Co-pay
Cost Per Month	ACTUAL 2010	ACTUAL 2010	ACTUAL 2010	ACTUAL 2010	ACTUAL 2010	ACTUAL 2010			ACTUAL 2010
Single-Family-	\$266.27	\$443.24	\$443.24	\$443.24	\$355.08	\$422.96			\$390.95
Sole Proprietor Single-	\$737.77	\$1229.91	\$1229.91	\$1229.91	\$984.43	\$1057.41			\$1014.45
Sole Prop. Family-									\$451.04 - SP
									\$1170.37 - SP

- RATES DO NOT include the \$15 quarterly administration fee. If you receive a monthly premium notice, rates will be different ~ COMMUNITY BLUE PLAN HMO 104 PLUS IS FOR EXISTING SUBSCRIBERS ONLY ~
- ♥ means \$0 copay for kids under age 18
- ★ means \$0 copay for well child visits under age 18 (age 19 for Blue Cross & Blue Shield)
- THIS IS A SUMMARY ONLY; PLEASE SEE PLAN BOOKLET FOR FULL DETAILS