Columbia County Chamber of Commerce Health Insurance Program
January 1, 2012 - December 31, 2012
Plan Comparison - QUARTERLY RATES

	Transitonal EPO	High Deductible EPO	High Deductible EPO	High Deductible PPO	
	EPOS0512	QEPOS0412	QEPOS1912	PJ1S12	
	In-Network	In-Network	In-Network	In-Network	Out-of-Network
	NOT HSA Compatible	HSA Compatible	HSA Compatible	HSA Compatible	
	Single/Family	Single/Family	Single/Family	Single/Family	Single/Family
Deductible (Single/Family)	$500/$1,250	$1,500/$3,000	$4,500/$9,000	$2,700/$5,400	$5,000/$10,000
Deductible Administration	Embeded for a Family: Deductible will not exceed the individual deductible amount for any one family member per benefit period	Aggregate for a Family: Deductible must be met in its entirety prior to the "coinsurance/copay/covered in full" portion being applied	Aggregate for a Family: Deductible must be met in its entirety prior to the "coinsurance/copay/covered in full" portion being applied	Aggregate for a Family: Deductible must be met in its entirety prior to the "coinsurance/copay/covered in full" portion being applied	
Coinsurance	10%	20%	Not Applicable	10%	50%
Annual Out of Pocket/Coinsurance Maximum	$2,000/$5,000 (Coinsurance Max)	$4,000/$8,000 (Coinsurance Max)	$5,500/$10,000 (OOP Max)	$4,000/$8,000 (Coinsurance Max)	$10,000/$20,000 (Coinsurance Max)
Annual Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Visit	$25 Copayment	Deductible Then 20% Coinsurance	Deductible Then Covered in Full	Deductible Then 10% Coinsurance	Deductible Then 50% Coinsurance
Specialist Visit	$25 Copayment	Deductible Then 20% Coinsurance	Deductible Then Covered in Full	Deductible Then 10% Coinsurance	Deductible Then 50% Coinsurance
Inpatient Hospitilization	Deductible Then 10% Coinsurance	Deductible Then 20% Coinsurance	Deductible Then Covered in Full	Deductible Then 10% Coinsurance	Deductible Then 50% Coinsurance
Emergency Room	Deductible Then 10% Coinsurance	Deductible Then 20% Coinsurance	Deductible Then Covered in Full	Deductible Then 10% Coinsurance	All Emergency Care Is Considered In Network
Ambulance	Deductible Then 10% Coinsurance	Deductible Then 20% Coinsurance	Deductible Then Covered in Full	Deductible Then 10% Coinsurance	All Emergency Care Is Considered In Network
Outpatient Surgery	Deductible Then 10% Coinsurance	Deductible Then 20% Coinsurance	Deductible Then Covered in Full	Deductible Then 10% Coinsurance	Deductible Then 50% Coinsurance
Prescription Drug	Pharmacy Copay is $4/$30/$60 w $2k max	N/A	$10 Tier 1 ONLY	N/A	
Skilled Nursing Rider	Extends SNF to 365 Days	N/A	N/A	N/A	
Out of Network Coverage	N/A	N/A	N/A	YES	
Website	www.CDPHP.com				

Quarterly Rates = Billed Every 3 Months (4 times per year). Rates include a $6/month administrative fee

	Transitonal EPO	High Deductible EPO	High Deductible EPO	High Deductible PPO
Single	**$1,404.03**	**$833.94**	**$400.83**	**$676.08**
Double	**$2,790.06**	**$1,649.88**	**$771.60**	**$1,334.16**
Family	**$3,690.99**	**$2,180.25**	**$1,016.55**	**$1,761.93**

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BlueShield of Northeastern New York	POS 250 D		Slate 7100	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Single/Family	Single/Family	Single/Family	Single/Family
	NOT HSA Compatible		HSA Compatible	
Deductible (Single/Family)	$1,000/$2,000	$2,000/$4,000	$1,500/$3,000 (Combined IN & OUT of Network)	
Deductible Administration	Family Deductible: No payments are made until the entire family deductible has been met. Any one family member can satisfy the full family deductible		The In-Network Deductible applies to ALL in network services except ROUTINE PREVENTIVE CARE. Family Deductible: No payments are made until the entire family deductible has been met. Any one family member can satisfy the full family deductible	
Coinsurance	20%	50%	N/A	30%
Annual Out of Pocket Maximum	$5,000/$10,000	$10,000/$20,000	$5,000/$10,000	$10,000/$20,000
Annual Benefit Maximum	Unlimited		Unlimited	
Primary Care Physician Visit	$25 Copay (Not Subject to Deductible)	Deductible then 50% Coinsurance	Deductible then $25 Copay	Deductible then 30% Coinsurance
Specialist Visit	$40 Copay (Not Subject to Deductible	Deductible then 50% Coinsurance	Deductible then $25 Copay	Deductible then 30% Coinsurance
Inpatient Hospitilization	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance	Deductible then $500 Copay	Deductible then 30% Coinsurance
Emergency Room	Deductible then 20% Coinsurance		Deductible then $50 Copay	
Ambulance (medically necessary)	Deductible then 20% Coinsurance		Deductible then $50 Copay	
Outpatient Surgery	20%	Deductible then 50% Coinsurance	Deductible then $75 Copay	Deductible then 30% Coinsurance
Prescription Drug	$15/$50/50% with $250 Deductible for Tier 2 and 3 per member		$15/$50/50% After Deductible is satisfied	
Skilled Nursing Rider	Unlimited, Deductible then 20% Coinsurance	Unlimited, Deductible then 50% Coinsurance	Unlimted, Deductible then $500 Copay	Deductible then 30% Coinsurance
Routine Vision Exam	1 Exam every 2 years, Covered in Full	N/A	1 Exam every 2 years, Covered in Full	N/A
Out of Network Coverage	Yes		Yes	
Website	www.BSNENY.com			

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	POS 250 D	Slate 7100
Single	**$1,060.26**	**$1,021.44**
Double	**$2,154.72**	**$2,075.01**
Family	**$2,978.28**	**$2,864.82**

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MVP HEALTH CARE	Transitonal EPO	High Deductible EPO	High Deductible EPO
	EC0034S	NECHD-31S	NECHD-29S
	In-Network	In-Network	In-Network
	Single/Family	Single/Family	Single/Family
	NOT HSA Compatible	HSA Compatible	HSA Compatible
Deductible (Single/Family)	$1,000/$2,500	$1,500/$3,000	$3,500/$7,000
Deductible Administration	Deductible is Embeded (one family member can satisfy just the Single deductible). Copays ARE NOT applicable toward the deductible or Out-of-pocket Maximum.	Family Aggregate - one or more family members' covered expenses must meet the family deductible amount each contract year before MVP will make benefit payments for all of the members of a family.	Family Aggregate - one or more family members' covered expenses must meet the family deductible amount each contract year before MVP will make benefit payments for all of the members of a family.
Coinsurance	20%	N/A	20%
Annual Out of Pocket Maximum	$3,000/$7,500	$3,000/$6,000 (Includes Prescription Drug Copayments)	$5,950/$11,900
Annual Benefit Maximum	Unlimited	Unlimited	Unlimited
Primary Care Physician Visit	$30	Deductible then $30 Copay	Deductible then 20% Coinsurance
Specialist Visit	$50	Deductible then $50 Copay	Deductible then 20% Coinsurance
Inpatient Hospitilization	Deductible then 20% Coinsurance	Deductible then $250 Copay	Deductible then 20% Coinsurance
Emergency Room	$200 Copay	Deductible then $150 Copay	Deductible then 20% Coinsurance
Ambulance	Deductible then 20% Coinsurance	Deductible then $150 Copay	Deductible then 20% Coinsurance
Outpatient Surgery	Deductible then 20% Coinsurance	Deductible then $200 Copay	Deductible then 20% Coinsurance
Prescription Drug	$10/$30/$50 **NOT** Subject to Deductible	$5/$35/$70 after Deductible is met	$5/$35/$70 after Deductible is met
Vision Rider	Exam $50 Copay/Visit, once every 2 calendar years; $100 Eyeglass and Contact Lens Allowance every 2 years	Routine Vision Exam $50 Copay/Visit after Deductible is met; $100 Eyeglass and Contact Lens Allowance every 2 calendar years after deductible is met	Routine Vision Exam subject to Deductible then 20%; $100 Eyeglass and Contact Lens Allowance every 2 calendar years after deductible is met
Out of Network Coverage	No	No	No
Website	www.MVPHealthcare.com		

Quarterly Rates = Billed Every 3 Months (4 times per year)

	Transitonal EPO	High Deductible EPO	High Deductible EPO
Single	**$1,788.78**	**$1,381.08**	**$911.37**
Double	**$3,559.56**	**$2,744.19**	**$1,804.77**
Family	**$4,622.04**	**$3,562.05**	**$2,340.81**

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	Plan ZD		Plan ZB	
Services	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Preventive Emergency Treatment, Examinations, Cleanings X-rays, Sealants	100% (**No Deductible**)	100%	100% (**No Deductible**)	100%
Basic Fillings, Oral Surgery Laboartory Tests	90%	80%	80%	80%
Major Crowns, Bridges, Periodontics, Endodontics - **6 Month Wait**	60%	50%	50%	0%
Dependent Age Limits	Dependents covered to age 20/Full Time Students to age 26			

In Network refers to providers that participate in Guardian network. Website: glic.com

Calendar Year Deductible $50 Individual, Max 3/Family

Calendar Year Benefit Maximum $1,000 Per Person

Deductibles and Maximums are combined for in-network and out of network services.

Participation Requirement: Businesses with 1-4 employees must have 100% enrollment of eligible employees, 5 - 49 employees 75% of eligible employees.

Member businesses can choose only one Guardian plan for their employees.
Groups that choose the ZB plan will not be able to switch to the ZD plan for a period of 2 years from initial enrollment.

Please check plan chosen for all employees:

Plan ZD _______________ Quarterly rates - Single - $121.14, Double - $329.79, Family - $329.79

Plan ZB _______________ Quarterly rates - Single - $103.65, Double - $276.78, Family - $276.78

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Columbia County Chamber of Commerce Vision Insurance Program
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Plan Comparison - QUARTERLY RATES

Empire BlueCross	**Blue View Vision**	
	In-Network	Out-of-Network
	Single/Family	**Single/Family**
COPAYMENT		
Examination	$10	Not Applicable
Eyeglass Lens	$10	Not Applicable
FREQUENCY OF SERVICE		
Exam	12 months	12 months
Lenses	12 months	12 months
Frames	12 months	12 months
Contact Lenses	12 months	12 months
PROFESSIONAL SERVICES		
Comprehensive Vision Examination	Covered in Full after Copayment	Up to $40 Allowance
BASIC LENSES (PAIR)		
Single Vision	Covered in Full after Copayment	Up to $25 Allowance
Bifocal	Covered in Full after Copayment	Up to $40 Allowance
Trifocal	Covered in Full after Copayment	Up to $55 Allowance
FRAME		
Eyeglasses frame allowance	$130 allowance, then 20% off remaining balance	Up to $45 allowance
CONTACT LENSES		
Elective Conventional	$130 allowance, then 15% off remaining balance	Up to $105 allowance
Elective Disposal	$130 allowance (no additional discount)	Up to $105 allowance
Non-Elective Contact Lenses	Covered in Full	Up to $210 allowance
Dependent Age Limits	Child to 25/Student to 26	

Rates are billed Quarterly (every 3 months) and include $6 Monthly Admin Fee (waived if more than one product is being billed)

Individual	**$38.79**
Double	**$58.53**
Family	**$78.30**

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