



THE WLADIS COMPANIES, INC.  
SINCE 1959

GROUP INSURANCE LIFE INSURANCE DISABILITY INSURANCE RETIREMENT PLANS CAFETERIA PLANS

## Herkimer County Chamber of Commerce Year 2010 Monthly Rate Comparison Sheet

Group of 2+				Plan Description	Sole Proprietor (Group of 1)			
Coverage Type – Monthly Rate					Coverage Type – Monthly Rate			
Single	Emp. + Spouse	Emp. + Child(ren)	Family		Single	Emp. + Spouse	Emp. + Child(ren)	Family
<b>Blue Cross/Blue Shield Plans</b>								
\$484.38	N/A	N/A	\$1,240.40	HMO Blue – \$25 Copay	\$532.83	N/A	N/A	\$1,364.44
\$425.24	\$850.48	\$860.29	\$1,186.77	HealthyBlue \$15/\$25 Copay + Deductible Plan	\$467.78	\$935.56	\$946.35	\$1,305.49
\$478.68	\$923.86	N/A	\$1,271.03	Blue Healthy Choices – Option B - \$20/\$25 Copay	\$526.56	N/A	N/A	\$1,349.37
\$485.03	N/A	N/A	\$1,235.09	Blue EPO Balance Option 7 (\$30 Copay) – <b>Closed to New Group Enrollments Effective 1/1/10</b>	\$533.53	N/A	N/A	\$1,358.60
\$255.13	\$510.26	\$519.15	\$716.16	HealthyBlue HDHP HSA \$2,600/\$5,200 Deductible Plan	\$280.65	\$561.30	\$571.06	\$787.77
\$390.89	\$781.78	\$790.78	\$1,090.87	SimplyBlue \$30/\$50 Copay Option – <b>New for 1/1/2010</b>	\$429.98	\$859.97	\$869.87	\$1,199.98
<b>MVP Health Care Plans</b>								
\$575.50	\$1,142.65	N/A	\$1,526.70	MVP Health Care – HMO 15	\$660.58	\$1,312.79	N/A	\$1,754.46
\$538.22	\$1,068.12	N/A	\$1,427.07	MVP Health Care – HMO 20	\$617.71	\$1,227.08	N/A	\$1,639.88
\$395.36	\$782.39	N/A	\$1,043.26	MVP Health Care – Preferred EPO \$30/\$50	\$453.41	\$898.50	N/A	\$1,198.51
\$522.40	\$1,036.47	N/A	\$1,383.32	MVP Health Care – TriVantage EPO	\$599.52	\$1,190.69	N/A	\$1,589.58
<b>CDPHP Plans</b>								
\$511.90	\$1,015.46	N/A	\$1,346.72	CDPHP – AvidCare 15 HMO	\$582.39	\$1,156.45	N/A	\$1,534.10
\$392.32	\$776.32	N/A	\$1,028.91	CDPHP – AttentiCare EPO	\$446.08	\$883.83	N/A	\$1,171.80
\$433.68	\$859.02	N/A	\$1,138.84	CDPHP – EPO \$30/\$50 Copay Plan – <b>New for 1/1/2010</b>	\$493.23	\$978.13	N/A	1,297.12
<b>Dental Plans</b>								
\$46.98	N/A	N/A	\$106.45	Blue Cross Prime Blue Dental <b>(Closed to New Group Enrollments Effective 1/1/09)</b>	Dental Options Not Available to Sole Proprietor Groups			
\$44.69	N/A	N/A	\$99.79	Dental Blue Options				

This chart is for the illustration of each plan's monthly premium rates. **All plans have specific enrollment & participation requirements. Enrollment in any of the plans listed above is contingent upon meeting all underwriting regulations imposed by each carrier.** If you are interested in receiving detailed information on any of the plans shown above, please contact Tina Crinnin, Cathy Dickson, Jennifer Sgroi or Sara Uruburu at Employee Benefits Plus, Inc. by phone (315) 474-1400 or toll free 1-800-724-0124, fax (315) 471-3042, or via email: [tina@wladisco.com](mailto:tina@wladisco.com), [cathy@wladisco.com](mailto:cathy@wladisco.com), [jennifer@wladisco.com](mailto:jennifer@wladisco.com), or [sara@wladisco.com](mailto:sara@wladisco.com)

# 2010 Blue Cross/Blue Shield Benefit Comparison - Herkimer County Chamber of Commerce

Services	HMO/Blue 25		Blue Healthy Choices - Option B No Out of Network Benefits		HealthyBlue HDHP HSA Plan - \$2,600/\$5,200 Deductible		HealthyBlue \$15/\$25 Copay + Deductible Plan		Simply Blue \$30/\$50 Copay Plan New for 1/1/2010	
	In Network Only	Office Visit Copay = \$25 Deductible = None Coinsurance = None Out of Pocket Maximum = None Referral = Required	FR & Healthy	Office Visit Copay = \$20 Deductible = None Coinsurance = None Out of Pocket Maximum = None	Out of Network	Office Visit Copay = \$25 Deductible = None Coinsurance = None Out of Pocket Maximum = None	In Network	Office Visit Copay = \$15 Deductible = \$2,600/\$5,200 Coinsurance = 0% Out of Pocket Maximum = \$5,500/\$11,000	Out of Network	Office Visit Copay = \$15 Deductible = \$2,600/\$5,200 Coinsurance = 0% Out of Pocket Maximum = \$5,500/\$11,000
Plan Type										
Office Visits	\$25 Copay PCP \$40 Copay Specialist		\$20 Copay PCP \$40 Copay Specialist		Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	PCP = Adults - \$15 Copay Kids to 19 - \$0 Copay Specialist = \$25 Copay	Covered @ 50%, subject to the deductible	PCP = \$30 Copay Specialist = \$50 Copay
Adult Physicals	\$25 Copay		\$20 Copay		Covered in full	Covered in full	Covered in full	Covered @ 50%, subject to the deductible	Covered in full	Covered @ 60%, subject to the deductible
Well Child Care	Covered in full		Covered in full		Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered @ 60%, subject to the deductible
Routine Mammography	\$25 Copay		Covered in full		Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered @ 60%, subject to the deductible
Routine Cervical Cancer Screening	\$25 Copay		Covered in full		Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered @ 60%, subject to the deductible
X-RAYS - Routine joint, skull, neck & extremity	\$40 Copay		\$40 Copay		Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	\$25 Copay	Covered @ 60%, subject to the deductible	\$75 Copay
Laboratory	\$25 Copay		Covered in full		Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	Covered in full	Covered in full	Covered @ 60%, subject to the deductible	\$50 Copay
Inpatient Hospital*	Covered in full after \$500 Copay		Covered in full after \$500 Copay		Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	Covered @ 80%, subject to the deductible	Covered @ 80%, subject to the deductible	Covered @ 50%, subject to the deductible	Covered @ 60%, subject to the deductible
Inpatient Surgery*	20% Coinsurance or \$200 Copay, whichever is less		20% Coinsurance or \$200 Copay, whichever is less		Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	Covered @ 80%, subject to the deductible	Covered @ 60%, subject to the deductible	Covered @ 60%, subject to the deductible
Maternity Care	Perinatal/Postnatal Office Visits: \$5 Copay for first 10 visits, remainder covered in full		Perinatal/Postnatal Office Visits: \$20 Copay for first 10 visits, remainder covered in full		Perinatal/Postnatal Office Visits: Covered @ 100%, subject to the deductible	Perinatal/Postnatal Office Visits: Covered @ 100%, subject to the deductible	Perinatal/Postnatal Office Visits: Covered @ 100%, subject to the deductible	Perinatal/Postnatal Office Visits: Covered @ 80%, subject to the deductible	Perinatal/Postnatal Office Visits: Covered @ 60%, subject to the deductible	Perinatal/Postnatal Office Visits: Covered @ 60%, subject to the deductible
Outpatient Surgery	Facility = Covered in full after \$900 Copay Physician = 20% Coinsurance or \$200 Copay, whichever is less		Facility = Subject to Physician = 20% Coinsurance or \$200 Copay, whichever is less		Hospital (including delivery): Covered @ 100%, subject to the deductible	Hospital (including delivery): Covered @ 100%, subject to the deductible	Hospital (including delivery): Covered @ 100%, subject to the deductible	Hospital (including delivery): Covered @ 80%, subject to the deductible	Hospital (including delivery): Covered @ 60%, subject to the deductible	Hospital (including delivery): Covered @ 60%, subject to the deductible
Emergency Room	\$100 Copay per visit		\$100 Copay per visit		Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	Covered @ 80%, subject to the deductible	Covered @ 60%, subject to the deductible	Covered @ 60%, subject to the deductible
Ambulance	\$100 Copay		\$100 Copay		100%/Deductible	100%/Deductible	100%/Deductible	\$150 Copay	100%/Deductible	\$250 Copay
Routine Eye Exams	\$40 Copay per eye exam every 2 years for adults, every year for kids to 19		\$20 Copay per eye exam every year for both Adults and Kids to 19		Covered @ 100%, subject to the deductible for 1 exam per year	Covered @ 100%, subject to the deductible for 1 exam per year	Covered @ 100%, subject to the deductible for 1 exam per year	Exam = \$25 Copay per 1 exam per year	Covered @ 60%, subject to the deductible	Exam = \$50 Copay per 1 exam per year
Eyewear Allowance	No Coverage		No Coverage		None	None	None	\$50 Eyewear Allowance once per year	\$60 Eyewear Allowance once per year	\$60 Eyewear Allowance once per year
Prescription Drug	Tier 1: \$10 Copay Tier 2: \$30 Copay Tier 3: \$50 Copay		Tier 1: \$10 Copay Tier 2: \$30 Copay Tier 3: \$50 Copay		Subject to Deductible & then: \$5 Copay - Tier 1 \$35 Copay - Tier 2 \$70 Copay - Tier 3 \$0 Copay on Generic Rx for Kids to age 19	No Coverage	Exam = \$25 Copay per 1 exam per year	\$250/\$50 Brand Deductible** & then: \$5 Copay - Tier 1 \$35 Copay - Tier 2 \$70 Copay - Tier 3 \$0 Copay for Generic Rx for Kids to age 19	No Coverage	Exam = 1 exam per year covered @ 60%, subject to the deductible
Health & Wellness	Blue 365 - Member Discount Program		\$300 annual allowance per family toward gym membership, LaSiK, teeth whitening, toddler gymnastics programs and kids' fitness activities.		Healthy Rewards: Earn up to \$1,000 per family per year for completing BCBS sponsored wellness programs. (\$500 for each subscriber & adult spouse/domestic partner)	Healthy Rewards: Earn up to \$1,000 per family per year for completing BCBS sponsored wellness programs. (\$500 for each subscriber & adult spouse/domestic partner)	Healthy Rewards: Earn up to \$1,000 per family per year for completing BCBS sponsored wellness programs. (\$500 for each subscriber & adult spouse/domestic partner)	Healthy Rewards: Earn up to \$1,000 per family per year for completing BCBS sponsored wellness programs. (\$500 for each subscriber & adult spouse/domestic partner)	Annual Maximum Contract: Allowance of up to \$300 for a health club/gym membership	Blue 365 - Member Discount Program
Dependent Coverage	Dependents to Age 19, Students to Age 25		Dependents to Age 19, Students to Age 25		Blue 365 - Member Discount Program	Blue 365 - Member Discount Program	Blue 365 - Member Discount Program	Blue 365 - Member Discount Program	Blue 365 - Member Discount Program	Blue 365 - Member Discount Program

\*Generic drugs do not apply to the annual brand deductible

\*\*Pre-Certification Required

This comparison is intended to be only a brief summary of plan benefits. This is NOT a contract. If your plan is not listed please contact our office to request a summary.

