



THE WLADIS COMPANIES, INC.
SINCE 1959

GROUP INSURANCE LIFE INSURANCE DISABILITY INSURANCE RETIREMENT PLANS CAFETERIA PLANS

Herkimer County Chamber of Commerce Year 2009 Monthly Plan/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
				Medicare Supplemental Plans				
\$444.89	N/A	N/A	\$886.45	Blue Cross/Blue Shield of Utica – Senior Coverage w/Rx	\$444.89	N/A	N/A	\$886.45
\$491.96	N/A	N/A	\$980.59	Blue Cross/Blue Shield of Utica – Blue Medallion Extended Health Care Benefits Rider (with Rx)	\$491.96	N/A	N/A	\$980.59
\$191.91	N/A	N/A	\$380.49	Blue Cross/Blue Shield of Utica – Senior Coverage	\$191.91	N/A	N/A	\$380.49
				Managed Care, EPO & PPO Plans				
\$448.28	N/A	N/A	\$1,134.79	HMO Blue – \$25 Copay	\$492.28	N/A	N/A	\$1,247.43
\$383.57	\$758.81	\$767.75	\$1,055.93	HealthyBlue \$15/\$25 Copay + Deductible Plan (New for 1/1/09)	\$421.10	\$833.87	\$843.70	\$1,160.70
\$424.56	\$811.65	N/A	\$1,113.78	Blue Healthy Choices – Option B - \$20/\$25 Copay	\$466.19	N/A	N/A	\$1,181.92
\$445.51	N/A	N/A	\$1,121.76	Blue EPO Balance – Option 7 - \$30 Copay	\$489.23	N/A	N/A	\$1,233.12
\$234.49	\$460.65	\$468.51	\$643.14	HealthyBlue HDHP HSA – Option 2 (New for 1/1/09)	\$257.11	\$505.89	\$514.53	\$706.62
\$188.59	N/A	N/A	\$468.51	BluePPO HSA (Health Savings Account) (Closed to New Group Enrollments Effective 1/1/09)	\$206.62	N/A	N/A	\$514.54
\$517.81	\$1,027.29	N/A	\$1,372.00	MVP Health Care – HMO 15	\$594.23	\$1,180.14	N/A	\$1,576.55
\$477.17	\$945.99	N/A	\$1,263.67	MVP Health Care – HMO 20	\$547.50	\$1,086.64	N/A	\$1,451.97
\$320.42	\$632.51	N/A	\$842.04	MVP Health Care – Preferred EPO \$30/\$50	\$367.24	\$726.13	N/A	\$967.10
\$414.30	\$820.28	N/A	\$1,093.33	MVP Health Care – TriVantage EPO (New for 1/1/09)	\$475.20	\$942.07	N/A	\$1,256.09
\$477.70	\$947.07	N/A	\$1,260.43	CDPHP – AvidCare 15 HMO	\$543.41	\$1,078.49	N/A	\$1,435.71
\$344.54	\$680.75	N/A	\$905.20	CDPHP – AttentiCare EPO	\$391.95	\$775.57	N/A	\$1,031.68
				Dental Plans				
\$46.36	N/A	N/A	\$104.64	Blue Cross Prime Blue Dental (Closed to New Group Enrollments Effective 1/1/09)	Dental Options Not Available to Sole Proprietor Groups			
\$44.47	N/A	N/A	\$99.16	Dental Blue Options (New for 1/1/09)				

This chart is to outline each plan's rates. **Each plan has specific enrollment rules. Enrollment in the above listed plans is based on meeting all underwriting regulations and participation requirements imposed by each carrier.** If you are interested in detailed information on any of the above listed plans please contact either Tina Crinnin, Cathy Dickson, Jennifer Sgroi or Sara Uruburu at Employee Benefits Plus, Inc. by phone (315) 474-1400 or 1-800-724-0124, fax (315) 471-3042, or via email : tina@wladisco.com ,cathy@wladisco.com, jennifer@wladisco.com, or sara@wladisco.com.

2009 Blue Cross/Blue Shield Benefit Comparison - Herkimer County Chamber of Commerce

Services	HMOBlue 25	BlueEPO Balance Option 7	Blue Healthy Choices - Option B No Out of Network Benefits		HealthyBlue HDHP HSA - Option 2		HealthyBlue Copay + Deductible Plan	
	No Out of Network Benefits	No Out of Network Benefits	Fit & Healthy	Healthy Family	In Network	Out of Network	In Network	Out of Network
	Plan Type	Office Visit Copay = \$25 Deductible = None Coinsurance = None Out of Pocket Maximum = None Referral = Required	Office Visit Copay = \$30 Deductible = None Coinsurance = None Out of Pocket Maximum = None Referral = Not Required	Office Visit Copay = \$20 Deductible = None Coinsurance = None Out of Pocket Maximum = None Referral = Not Required	Office Visit Copay = \$25 Deductible = None Coinsurance = None Out of Pocket Maximum = None Referral = Not Required	OV Copay = N/A Deductible = \$2,600/\$5,200 Coinsurance = 0% Out of Pocket Maximum = \$5,500/\$11,000 Referral = Not Required	OV Copay = N/A Deductible = \$2,600/\$5,200 Coinsurance = 0% Out of Pocket Maximum = \$5,500/\$11,000 Referral = Not Required	OV Copay = \$15 Deductible = \$500/\$1,500 Coinsurance = 20% Out of Pocket Maximum = \$1,500/\$4,500 Referral = Not Required
Office Visits	\$25 Copay PCP \$40 Copay Specialist	\$30 Copay \$30 Copay Specialist	\$20 Copay PCP \$40 Copay Specialist	\$25 Copay PCP - Adults \$0 Copay PCP - Kids to 19 \$40 Copay Specialist	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 at 60%, subject to the deductible
Adult Physicals	\$25 Copay	\$30 Copay	\$20 Copay	\$25 Copay	Covered in full	Covered @ 100%, subject to the deductible	Covered in full	Covered @ 60%, subject to the deductible
Well Child Visits	Covered in full	Covered in full	Covered in full		Covered in full	Covered in full	Covered in full	Covered in full
Routine Mammography	\$25 Copay	Covered in full	Covered in full		Covered in full	Covered @ 100%, subject to the deductible	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 @ 100%, subject to the deductible	Covered in full	Covered @ 60%, subject to the deductible
X-rays (including MRI, MRA, PET & CAT Scans)*	\$40 Copay	\$30 Copay	\$40 Copay		Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	\$25 Copay	Covered @ 60%, subject to the deductible
Laboratory	\$25 Copay	Physician Office = Covered in full Outpatient Hospital = \$30 Copay	Covered in full		Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	Covered in full	Covered @ 60%, subject to the deductible
Inpatient Hospital*	Covered in full after \$500 Copay	Covered in full	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 @ 60%, subject to the deductible
Inpatient Surgery*	20% Coinsurance or \$200 Copay, whichever is less	Covered in full	20% Coinsurance or \$200 Copay, whichever is less		Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	Covered @ 80%, subject to the deductible	Covered @ 60%, subject to the deductible
Maternity Care	Prenatal/Postnatal Care: \$5 Copay for first 10 visits, remainder covered in full	Prenatal/Postnatal Care: \$30 Copay per visit	Prenatal/Postnatal Care: \$20 Copay for first 10 visits, remainder covered in full	Prenatal/Postnatal Care: Covered in full	Prenatal/Postnatal: Covered @ 100%, subject to the deductible	Prenatal/Postnatal: Covered @ 100%, subject to the deductible	Prenatal/Postnatal: Covered @ 80%, subject to the deductible	Prenatal/Postnatal: Covered @ 60%, subject to the deductible
	Hospital Care for Mom: Facility = Covered in full after \$500 Copay Physician = 20% Coinsurance or \$200 Copay, whichever is less	Hospital Care for Mom (including delivery): Covered in Full	Hospital Care for Mom: Facility = Covered in full after \$500 Copay Physician = 20% Coinsurance or \$200 Copay, whichever is less	Hospital Care for Mom: Facility = Covered in full Physician = Covered in full	Hospital Care for Mom (including delivery): Covered @ 100%, subject to the deductible	Hospital Care for Mom (including delivery): Covered @ 100%, subject to the deductible	Hospital Care for Mom (including delivery): Covered @ 80%, subject to the deductible	Hospital Care for Mom (including delivery): Covered at 60%, subject to the deductible
	Newborn Nursery Care: Covered in full	Newborn Nursery Care: Covered in full	Newborn Nursery Care: Covered in full		Newborn Nursery Care: Covered @ 100%, subject to the deductible	Newborn Nursery Care: Covered @ 100%, subject to the deductible	Newborn Nursery Care: Covered in full	Newborn Nursery Care: Covered @ 60%, subject to the deductible
Outpatient Surgery	Facility = \$75 Copay Physician = 20% Coinsurance or \$200 Copay, whichever is less	\$50 Facility Copay	Facility = \$75 Copay Physician = \$40 Copay		Covered @ 100%, subject to the deductible	Covered @ 100%, subject to the deductible	Covered @ 80%, subject to the deductible	Covered @ 60%, subject to the deductible
Emergency Room	\$100 Copay per visit	\$50 Copay per visit	\$100 Copay per visit		100%/Deductible	100%/Deductible	\$150 Copay	\$150 Copay
Ambulance	\$100 Copay	\$50 Copay	\$100 Copay		100%/Deductible	100%/Deductible	\$150 Copay	\$150 Copay
Routine Eye Exams	\$40 Copay per one exam every 2 years for adults, every year for kids to age 19	\$30 Copay per one exam every 2 years	\$20 Copay per one exam every year for both Adults and Kids to age 19	\$25 Copay - Adults \$0 Copay - Kids to age 19 (one 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	Exam = Covered @ 60%, subject to the deductible
Eyewear Allowance	No Coverage	No Coverage	No Coverage	\$100 allowance for Kids to age 19 every year	None	None	\$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: \$25 Copay Tier 3: \$40 Copay \$0 Copay on Generic Rx for kids to age 19 \$1000 per Individual Calendar Year Maximum	Tier 1: \$10 Copay Tier 2: \$30 Copay Tier 3: \$50 Copay \$0 Copay on Generic Rx for Kids to age 19		Subject to Deductible: \$5 Copay - Tier 1 \$35 Copay - Tier 2 \$70 Copay - Tier 3 \$0 Copay on Generic Rx for Kids to age 19	No Coverage	\$250/\$750 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
Health & Wellness	Member Rewards Program	Member Rewards Program	\$300 annual allowance per family toward gym membership, Lasik, teeth whitening, toddler gym/swim programs and drivers education	\$100 annual allowance per family toward gym membership, Lasik, teeth whitening, toddler gym/swim programs and drivers education	Healthy Rewards: Earn up to \$1,000 per family per year for completing BCBS sponsored wellness programs. (\$1,000 per family is for each subscriber & adult spouse/domestic partner)		Healthy Rewards: Earn up to \$1,000 per family per year for completing BCBS sponsored wellness programs. (\$1,000 per family is for each subscriber & adult spouse/domestic partner)	
Dependent Coverage	Dependents to Age 19, Students to Age 25	Dependents to Age 19, Students to Age 23	Dependents to Age 19, Students to Age 25		Qualified Dependents to Age 26		Qualified Dependents to Age 26	

*Pre-Certification Required

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

This comparison is intended to be only a **brief** summary of plan benefits. This is **NOT** a contract.

