

Summary of Benefits for: Wyoming Chamber of Commerce



BlueCross BlueShield
of Western New York

A Division of HealthNow New York Inc. An Independent
Licensee of the BlueCross BlueShield Association

Highlights of HealthyBalance POS 8100 26/26 HDHP
Healthy Balance POS 8100 Plan 1 - CHMB

In-Network

Doctor's Visit

PCP Office visits	20% after deductible
PCP Office visits for dependents under age 19	20% after deductible
Well child visits and immunizations (to age 19)	Covered in full
Specialist visits	20% after deductible
Routine physical	Covered in full
Allergy immunotherapy	20% after deductible

Diagnostic Testing

Diagnostic X-rays	20% after deductible
Laboratory testing	20% after deductible
MRI	20% after deductible

Women's Services

Gynecological office visits (Routine)	Covered in full; (2 per year)
Mammograms (Routine)	Covered in full
Maternity care (routine prenatal & post-natal care)	20% after deductible
Inpatient maternity stay	20% after deductible
Pap smears (Routine)	Covered in full

Management and Treatment

Alcohol & substance abuse	60 Outpatient visits; 20% after deductible
Cardiac rehabilitation	20% after deductible; (24 aggregate visits in 12 weeks)
Chemotherapy	20% after deductible
Radiation therapy	20% after deductible
Chiropractic care	20% after deductible
Diabetic equipment & supplies	20% after deductible
Durable medical equipment	20% after deductible
Mental health	20 Outpatient visits; 20% after deductible
Physical, speech & occupational therapy	20% after deductible; (30 aggregate visits)
Prosthetics & orthotic appliances	20% after deductible
Post-mastectomy prosthetics	20% after deductible

Hospital, Facility and Home Services

7 days IP detoxification; 20% after

Alcohol & substance abuse (detoxification)	deductible
Alcohol & substance abuse (rehabilitation)	30 days IP rehab; 20% after deductible
Emergency ambulance (medically necessary)	20% after deductible
Emergency room (copay waived if admitted to hospital)	20% after deductible
Home care	40 days; 20% after deductible
Hospice	20% after deductible; Unlimited visits
Hospital stay (semi-private room)	20% after deductible
Mental Health	30 days; 20% after deductible
Skilled nursing facility (non-custodial)	60 days; 20% after deductible
Surgery (outpatient facility)	20% after deductible
Urgent care	20% after deductible

Dependent Coverage

Dependent/Student	26/26
Domestic partner	Not Covered

Extras

Routine vision exam	Covered in full; 1 every 2 yrs, 1 per yr for under 14 w/diag refractive
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Prescription Drug Coverage

Prescription drug	\$15/\$50/50% after deductible
Mail order	2.5 copay - 90 day supply

Out-of-Pocket Expenses

Annual deductible	\$1,500 single/\$3,000 true family (combined in and out-of-network)
Coinsurance	In-Network - 20%; Out-of-Network -40%
Annual out-of-pocket maximum	INN - \$4,000/\$8,000 true family; OON - \$10,000/\$20,000
Annual maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited

Benefit Administration

Benefit administration	Calendar year
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- Family Deductible - No payments are made until the entire family deductible has been met.
- Triple Rx options with coinsurance on the 3rd tier will require at least the 2nd tier copay.
- This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan.