

Wyoming County Chamber of Commerce  
Preferred Care  
Rochester Area  
(network includes some Buffalo area providers)

Plans Effective: 01/01/09	TriVantage 250-1			Basix 220-3
	In Network		Out of Network	In Network Only No Out of Network Benefit
<b>Annual Deductible &amp; Coinsurance</b>				
Annual Deductible:	n/a		Limited Benefit	
Out of Pocket Maximum:	n/a		with the Healthy	
Coinsurance:	n/a		Alternatives	
Annual Maximum Benefit:	n/a		Option Only	No Limit Health (see Rx)
Lifetime Maximum Benefit:	No Limit			No Limit Health (see Rx)
	In Network Services One Plan - Choose Option			In Network Services
<b>Office Visits</b>	Active Lifestyles	Family Focus	Health Alternatives	
Primary Care Phys. Age 0 - 18	20 (0 < age 18)	5 (0 < age 5)	20 (0 < age 18)	25 (0 - well)
Primary Care Phys. Age 19+	10	15	20	25
Specialist	20	20	20	40
<b>Women's Services</b>				
Maternity Inpatient	100	0	100	500
Routine GYN Visits	5	10	15	25
Mammograms	0	0	0	25
<b>Inpatient Hospital Care</b>				
Semi-private room	300	300 (0 < age 19)	300	500
<b>Outpatient Surgery</b>				
Hospital / Ambulatory Facility	75	75	75	75
Physician Charges	20% to 25	20% to 25	20% to 25	40
<b>Diagnostic Services</b>				
Laboratory	5	5	5	15
X-Rays	20	20	20	40
<b>Emergency Care</b>				
Emergency room visit	40	50	50	75
Emergency ambulance	25	25% to 100	25% to 100	50
After Hours Care Center	25	30	30	35
<b>Mental Health Care</b>				
Inpatient	300	300 (0 < age 19)	300	500
Outpatient - 20 visits / year	20	20	20	40
<b>Substance Abuse Treatment</b>				
Inpatient (detoxification only)	300	300 (0 < age 19)	300	Not Covered
Outpatient treatment	20	20	20	25
<b>Other Services</b>				
Chiropractic care	20	20	20	40
Durable Medical Equipment	50%	50%	50%	50%
Annual Benefit Limit:	\$5,000	\$5,000	\$5,000	\$5,000
Skilled nursing facility (non cust.)	300	300 (0 < age 19)	300	Not Covered
Home Care Services	20	20	20	25
<b>Annual Lifestyle Allowance</b>	Up to \$300	Up to \$300	Discounts	n/a
<b>Dependent Coverage</b>	26	26	26	19 / 23
<b>Prescription Drugs</b>	10 / 25 / 40	10 / 25 / 40	10 / 25 / 40	10 / 25 / 40
Annual Rx Benefit Limit:	No Limit			\$1,000 per family member
<b>Monthly Rates</b>				
Single:		\$405.07		\$268.19
Two-Person:		\$911.45		\$603.46
Family:		\$1,053.21		\$697.31

Note: This summary compares certain benefit components of the featured plans and it is to be used for general comparison purposed only. Inadvertant discrepancies may occur between this summary and the plan documents. For each plan, the plan documents prepared by the carrier must be examined for a complete and detailed schedule of benefits, terms, conditions, limitations and exclusions.

Wyoming County Chamber of Commerce  
Preferred Care  
New & Additional Plans for 2009

	<b>New Plan</b>	<b>New Plan</b>	<b>New Plan</b>	
<b>Plans Effective: 01/01/09</b>	<b>Basix 220-2</b>	<b>Preferred EPO 2</b>	<b>MyCare 680-1</b>	
	In Network Only	In Network Only	In Network	Out of Network
<b>Annual Deductible &amp; Coinsurance</b>				
Annual Deductible:	No Out of Network Benefit	National Network	\$1,300 / \$2,600 (combined in & out)	
Out of Pocket Maximum:			\$3,000 / \$6,000 (combined in & out)	
Coinsurance:			20% (most services)	40% (most services)
Annual Maximum Benefit:	No Limit	No Limit	No Limit	No Limit
Lifetime Maximum Benefit:	No Limit	No Limit	No Limit	No Limit
	In Network Services	In Network Services	In Network	Out of Network
<b>Office Visits</b>				
Primary Care Phys. Age 0 - 18	20 (0 - well)	20 (0 - well)	20% after Ded (0-well)	40% after Ded
Primary Care Phys. Age 19+	20	20	20% after Ded	40% after Ded
Specialist	20	20	20% after Ded	40% after Ded
<b>Women's Services</b>				
Maternity Inpatient	250	300	500 after Ded	40% after Ded
Routine GYN Visits	20	20	0 - Covered in Full	40% after Ded
Mammogram - Routine	20	0	0 - Covered in Full	40% after Ded
<b>Inpatient Hospital Care</b>				
Semi-private room	250	300	20% after Ded	40% after Ded
<b>Outpatient Surgery</b>				
Hospital / Ambulatory Facility	100	100	20% after Ded	40% after Ded
Physician Charges	20		20% after Ded	40% after Ded
<b>Diagnostic Services</b>				
Laboratory	10	0	20% after Ded	40% after Ded
X-Rays	20	20	20% after Ded	40% after Ded
<b>Emergency Care</b>				
Emergency room visit	50	50	20% after Ded	20% after Ded
Emergency ambulance	50	20	20% after Ded	20% after Ded
After Hours Care Center	25		20% after Ded	20% after Ded
<b>Mental Health Care</b>				
Inpatient	250	300	20% after Ded	40% after Ded
Outpatient	20	20	20% after Ded	40% after Ded
<b>Substance Abuse Treatment</b>				
Inpatient (detoxification only)	Not Covered	300	20% after Ded	40% after Ded
Outpatient treatment	20	20	20% after Ded	40% after Ded
<b>Other Services</b>				
Chiropractic care	20	20	20% after Ded	40% after Ded
Durable Medical Equipment	50%	20%	20% after Ded	40% after Ded
Annual Benefit Limit:	\$5,000	\$7,500	\$5,000	
Skilled nursing facility (non cust.)	Not Covered	300	20% after Ded	40% after Ded
Home Care Services	20	20	25% after Ded	25% after Ded
<b>Dependent Coverage</b>	26	26	26	
<b>Prescription Drugs</b>	10 / 25 / 40	10 / 30 / 50	10% / 30% / 50% After Ded.	
<b>Monthly Rates</b>				
Single:	\$327.24	\$323.02	\$193.00	
Two-Person:	\$736.34	\$742.94	\$443.87	
Family:	\$861.41	\$879.12	\$525.25	

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Wyoming County Chamber of Commerce  
BlueCross BlueShield of Western New York - Buffalo Area

Plans Effective: 01/01/09	New Plan - Open to All		Closed Plan		Closed Plan		New Plan - Open to All	
	CB HMO 206		CB HMO 104		CB POS 150 D		POS 7100-Plan 4	
							HSA Qualified - High Ded.	
	In Network	Out of Network Plus Options Only	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Annual Deductible &amp; Coinsurance</b>								
Annual Deductible:	n/a	\$1,000 / \$2,000	n/a	\$1,000 / \$2,000	\$500 / \$1,000	\$2,000 / \$4,000	\$1,500 / \$3,000 (combined in & out)	
Out of Pocket Maximum:	n/a	\$5,000 / \$10,000	n/a	\$5,000 / \$10,000	\$2,500 / \$5,000	\$10,000 / \$20,000	\$5,000 / \$10,000	\$10,000 / \$20,000
Coinsurance:	n/a	30%	n/a	30%	10% (certain services)	40%	n/a	30%
Annual Maximum Benefit:	No Limit	No Limit	No Limit	\$100,000	No Limit	\$100,000	No Limit	No Limit
Lifetime Maximum Benefit:	No Limit	No Limit	No Limit	1 Million	No Limit	1 Million	No Limit	No Limit
	In Network Services		In Network Services		In Network Services		In Network	Out of Network
	Original Option	Plus Copay Options						
<b>Office Visits</b>								
Primary Care Phys. Age 0 - 18	0	0	0	0	0	0	0 after Ded	Ded+Coins
Primary Care Phys. Age 19+	25	20 or 10	25	25	20	20	0 after Ded	Ded+Coins
Specialist	25	30 or 40	40	40	20	20	0 after Ded	Ded+Coins
<b>Women's Services</b>								
Maternity Inpatient	0	0	0	0	10% Coins. after Ded.		0 after Ded	Ded+Coins
Routine GYN Visits	25	20 or 10	25	25	20		0-Covered in Full	Ded+Coins
Mammogram - Routine	0	0	0	0	0		0- Covered in Full	Ded+Coins
<b>Inpatient Hospital Care</b>								
Semi-private room	250	250	500	500	10% Coins. after Ded.		0 after Ded	Ded+Coins
<b>Outpatient Surgery</b>								
Hospital / Ambulatory Facility	75	75	75	75	10% Coins. after Ded.		0 after Ded	Ded+Coins
<b>Diagnostic Services</b>								
Laboratory	0	0	0	0	10% Coins. after Ded.		0 after Ded	Ded+Coins
X-Rays	25	30 or 40	40	40	10% Coins. after Ded.		0-after Ded	Ded+Coins
<b>Emergency Care</b>								
Emergency room visit	100	100	100	100	100 after Ded		0 after Ded	Ded+Coins
Emergency ambulance	100	100	100	100	100 after Ded		0-after Ded	Ded+Coins
After Hours Care Center							0-after Ded	Ded+Coins
<b>Mental Health Care</b>								
Inpatient	250	250	500	500	10% Coins. after Ded.		0 after Ded	Ded+Coins
Outpatient	25	30 or 40	40	40	20		0-after Ded	Ded+Coins
<b>Substance Abuse Treatment</b>								
Inpatient (detoxification only)	250	250	500	500	10% Coins. after Ded.		0 after Ded	Ded+Coins
Outpatient treatment	25	30 or 40	40	40	20		0-after Ded	Ded+Coins
<b>Other Services</b>								
Chiropractic care	15	15	40	40	20		0 after Ded	Ded+Coins
Durable Medical Equipment	50%	50%	50% after Ded	50% after Ded	50% after Ded		0-after Ded	Ded+Coins
Annual Benefit Limit:	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000			\$1,000
Skilled nursing facility (non cust.)	250	250	500	500	10% Coins. after Ded.		0 after Ded	Ded+Coins
Home Care Services	25	30 or 40	40	40	20		0-after Ded	Ded+Coins
<b>Dependent Coverage</b>	19 / 25	19 / 25	19 / 25	19 / 25	19 / 25		19/25	19/25
<b>Prescription Drugs (see below)</b>	15 / 50 / 50 Percent	15 / 50 / 50 Percent	15 / 50 / 50 Percent	15 / 50 / 50 Percent	15 / 50 / 50 Percent		15 / 50 / 50 Percent	After Ded.
<b>Monthly Rates</b>								
Single:		\$392.05		\$312.45		\$213.93		\$209.79
Family:		\$1,087.76		\$866.46		\$593.70		\$581.33

**Prescription Drugs - All BCBS Plans: Mail Order is Mandatory for Maintenance Drugs (only 2 fills allowed at retail pharmacy)**

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Wyoming County Chamber of Commerce  
Independent Health and Univera Plans

	Buffalo Area			Buffalo & Rochester Areas	
Plans Effective: 01/01/09	Independent Health FlexFit Select			Univera Healthcare Simply Univera	
	In Network		Out of Network	In Network Only	
<b>Annual Deductible &amp; Coinsurance</b>				No Out of Network Benefit	
Annual Deductible:	n/a		\$1,000 / \$2,000	Plan Provides Access	
Out of Pocket Maximum:	n/a		\$5,000 / \$10,000	to the Univera Healthcare	
Coinsurance:	n/a		30%	and Excellus Networks	
Annual Maximum Benefit:	n/a		No Limit	No Limit Health (see Rx)	
Lifetime Maximum Benefit:	No Limit		No Limit	No Limit Health (see Rx)	
	In Network Services			In Network Services	
	One Plan - Choose Option				
<b>Office Visits</b>	Active	Family	Independent		
Primary Care Phys. Age 0 - 18	25 (0 - well)	0	25 (0 - well)	30 (0 - well)	
Primary Care Phys. Age 19+	15	25	25	30	
Specialist	40	40	40	50	
<b>Women's Services</b>					
Maternity Inpatient	500	0	500	500	
Routine GYN Visits	15 or 25	25	25	30	
Mammograms	0	0	0	30	
<b>Inpatient Hospital Care</b>					
Semi-private room	500	500 (0 < age 19)	500	500	
<b>Outpatient Surgery</b>					
Hospital / Ambulatory Facility	75	75	75	75	
<b>Diagnostic Services</b>					
Laboratory	0	0	0	0	
X-Rays	40	40	40	30	
<b>Emergency Care</b>					
Emergency room visit	100	100	100	100	
Emergency ambulance	100	100	100	100	
After Hours Care Center	45	45	45	50	
<b>Mental Health Care</b>					
Inpatient	500	500 (0 < age 19)	500	500	
Outpatient - 20 visits / year	40	40	40	50	
<b>Substance Abuse Treatment</b>					
Inpatient (detoxification only)	500	500 (0 < age 19)	500	500	
Outpatient treatment	40	40	40	30	
<b>Other Services</b>					
Chiropractic care	25	25	25	30	
Durable Medical Equipment	50%	50%	50%	50%	
Annual Benefit Limit:	\$1,000	\$1,000	\$1,000	\$1,000	
Skilled nursing facility (non cust.)	500	500 (0 < age 19)	500	500	
Home Care Services	40	40	40	30	
<b>Annual Lifestyle Allowance</b>	\$250.00	\$250.00	\$250.00	n/a	
<b>Dependent Coverage</b>	19	23	26	19 / 23	
<b>Prescription Drugs</b>	\$10 Generic Only	\$10 Generic Only	\$10 Generic Only	7 / 50 / 100	
Annual Rx Benefit Limit:	No Limit - Be Aware - Plan Covers Generic Drugs ONLY			\$1,000 per family member	
<b>Monthly Rates</b>				Group	Sole Proprietor
Single:	\$367.71			\$344.74	\$396.47
Family:	\$937.66			\$894.55	\$1,028.78

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