

**SARATOGA COUNTY CHAMBER OF COMMERCE PROPOSED 2012 HIGH DEDUCTIBLE HEALTH CARE OPTIONS SUMMARY**

Please contact the Chamber Benefits Office at 584-3255, Ext. 211, Or [srowland@saratoga.org](mailto:srowland@saratoga.org) for current information

| QUARTERLY RATES <i>Includes \$21 Administrative Fee</i>        | BLUE SHIELD POS 7100 High Deductible<br><a href="http://www.bsny.com">www.bsny.com</a>   | CDPHP PPO High Deductible<br><a href="http://www.cdphp.com">www.cdphp.com</a>  |                 | MVP EPO High Deductible<br><a href="http://www.mvphealthcare.com">www.mvphealthcare.com</a>  |                 |
|--|--|--|-----------------|--|-----------------|
|  | Small Business and Sole Proprietor   | Small Business   | Sole Proprietor | Small Business   | Sole Proprietor |
| Individual   | 1024.44  | 593.73   | 673.92          | 979.77   | 1123.59         |
| Two-Person   | 2078.01  | 1124.07  | 1278.48         | 1938.54  | 2226.18         |
| Family   | 2867.82  | 1482.57  | 1687.17         | 2513.79  | 2887.71         |
| Eligibility  | Business Tax Documentation Required  | Business Tax Documentation Required  |                 | Business Tax Documentation Required  |                 |
| <u>When to Apply</u>   | Immediately as a new Chamber member or new hire  | Immediately as a new Chamber member or new hire  |                 | Immediately as a new Chamber member or new hire  |                 |
| <u>When will it be effective?</u>                              | <u>Small Businesses:</u> 1 <sup>st</sup> of month following 30 days after Chamber Join Date or Employee Hire Date<br><u>Sole Proprietors:</u> 1 <sup>st</sup> of month following 60 days after Chamber Join Date | <u>Small Businesses:</u> 1 <sup>st</sup> of month following 30 days after Chamber Join Date or Employee Hire Date<br><u>Sole Proprietors:</u> 1 <sup>st</sup> of month following 60 days after Chamber Join Date |                 | <u>Small Businesses:</u> 1 <sup>st</sup> of month following 30 days after Chamber Join Date or Employee Hire Date<br><u>Sole Proprietors:</u> 1 <sup>st</sup> of month following 60 days after Chamber Join Date |                 |
| <u>Open Enrollment</u>   | Apply in November for January 1 Coverage   | Apply in November for January 1 Coverage<br>OR in May for July 1 Coverage  |                 | Apply in November for January 1 Coverage<br>OR in May for July 1 Coverage  |                 |
| <u>Dependent Coverage</u>                                      | Spouse & Children to Age 26  | Spouse & Children to Age 26  |                 | Spouse & Children to Age 26  |                 |
| <u>Deductible</u>  | \$1500 Single/\$3000 Family Combined In and Out-of-Network<br>30% Co-insurance Out-of-Network  | \$3500 Single/\$7000 Family Aggregate In-Network<br>\$6000 Single/\$12,000 Family Aggregate Out-of-Network   |                 | \$2500 Single/\$5000 Family  |                 |
| <u>Annual Out-of-Pocket Max</u>                                | \$5000 Single/\$10,000 Family, In Network<br>\$10,000 Single/\$20,000 Family Out-of-Network  | \$5300 Single/\$10,600 Family, In Network<br>\$10,000 Single/\$20,000 Family, Out-of-Network   |                 | \$5000 Single/\$10,000 Family<br>Includes Deductible, Prescription and Medical Copays  |                 |
| <u>Annual and Lifetime Benefit</u>                             | Unlimited  | Unlimited  |                 | Unlimited  |                 |
| <u>PCP/Specialist Office Visit</u>                             | \$25/\$25 Copay after Deductible   | 10% Co-insurance after Deductible In Network<br>50% Co-insurance after Deductible Out-of-Network   |                 | \$30/\$50 Copay after Deductible   |                 |
| <u>Hospital In-Patient</u>                                     | \$500 Copay after Deductible   | 10% Co-insurance after Deductible In Network<br>50% Co-insurance after Deductible Out-of-Network   |                 | \$500 Copay after Deductible   |                 |
| <u>Out-Patient Surgery</u>                                     | \$75 Copay after Deductible  | 10% Co-insurance after Deductible In Network<br>50% Co-insurance after Deductible Out-of-Network   |                 | \$200 Copay after Deductible   |                 |
| <u>Emergency Room</u>  | \$50 Copay after Deductible  | 10% Co-insurance after Deductible In or Out-of-Network   |                 | \$150 Copay after Deductible   |                 |
| <u>Urgent Care</u>   | \$35 Copay after Deductible  | 10% Co-insurance after Deductible In Network<br>50% Co-insurance after Deductible Out-of-Network   |                 | \$50 Copay after Deductible  |                 |
| <u>Prescription</u>  | \$15/\$50/50% after Deductible   | \$4/50%/50% after Deductible   |                 | \$5/\$35/\$70 Copay after Deductible   |                 |
| <u>Routine Vision Exam</u>                                     | Covered in Full after Deductible, Once Every Two Years   | Not Covered  |                 | \$50 Copay after Deductible Every 2 Years<br>\$100 Eyewear Allowance after Deductible Every 2 Years  |                 |
| <u>Maternity Care – Physician</u>                              | \$25 Copay after Deductible  | 10% Co-insurance after Deductible In Network   |                 | \$30 Copay then Covered in Full  |                 |
| <u>Maternity Care – Hospital</u>                               | \$500 Copay after Deductible   | 50% Co-insurance after Deductible Out-of-Network   |                 | \$500 Copay after Deductible   |                 |
| <u>Mental Health In-Patient</u>                                | \$500 Copay after Deductible<br>30 Days  | 10% Co-insurance after Deductible In Network<br>50% Co-insurance after Deductible Out-of-Network<br>30 Days  |                 | \$500 Copay after Deductible<br>30 Days  |                 |
| <u>Mental Health Out-Patient</u>                               | \$25 Copay after Deductible<br>20 Visits   | 10% Co-insurance after Deductible In Network<br>50% Co-insurance after Deductible Out-of-Network<br>20 Visits  |                 | \$50 Copay<br>20 Visits  |                 |
| <u>Rehabilitative Therapy (Physical, Occupational, Speech)</u> | \$25 Copay after Deductible<br>30 Aggregate Visits: PT, OT and ST  | 10% Co-insurance after Deductible In Network<br>50% Co-insurance after Deductible Out-of-Network<br>PT – 30 Days; OT - 30 Days; ST - 20 Days   |                 | \$50 Copay after Deductible<br>30 Aggregate Visits; PT, OT, ST   |                 |
| <u>Chiropractic Care</u>                                       | \$25 Copay after Deductible  | 10% Co-insurance after Deductible In Network<br>50% Co-insurance after Deductible Out-of-Network   |                 | \$50 Copay after Deductible  |                 |

**Preventive Services** – Including Well Baby, Child Care & Immunizations; Adult Annual Physical; Mammography & Prostate Cancer Screening; Annual Pap Test and OB/Gyn Exam; Colonoscopy and Sigmoidoscopy Screening for Adults are not subject to the deductible with a \$0 Copay on these plans.

THE ABOVE INFORMATION IS A SUMMARY OF SELECTED BENEFITS FOR COMPARATIVE PURPOSES ONLY. COVERAGE IS SUBJECT TO THE TERMS, CONDITIONS AND LIMITATIONS OF THE APPLICABLE GROUP CONTRACT AND CERTIFICATE OF INSURANCE. **RATES AND BENEFITS ARE SUBJECT TO CHANGE.**