Open Enrollment Dates: **June 1st and December 1st**

The Gore Mountain Chamber of Commerce-Health Insurance Outline				Revised 6/22/2010
Rates Effective June 1, 2010 thru May 31, 20010				
Options	**EPO $25**	*(New for 2010)* **EPO $30-50**	**HIGH DEDUCTIBLE PPO**	
Type of Plan	In network only	In network only	In Network	Out of Network
Plan Benefits	Single/Family	Single/Family	Single/Family	Single/Family
Embedded Deductible (Single/Family)	$500/$1,250	N/A	$2,700/$5,400	$5,000/$10,000
Coinsurance Requirement	20%	N/A	10%	50%
Out of Pocket/Coinsurance Maximum	$2,000/$5,000	N/A	$4,000/$8,000	$10,000/$20,000
Annual Benefit Max	$1,000,000	$1,000,000	$1,000,000 (In Network/Out Of Network Combined)	
Physician Services				
Office visits for illness, injury or second opinion (PCP/OBGYN)	$25 Per Visit. No deductible	$30 Copayment	Deductible then 10% Coinsurance	Deductible then 50% Coinsurance
Office visits for illness, injury or second opinion (Specialist)	$25 Per Visit. No deductible	$50 Copayment	Deductible then 10% Coinsurance	Deductible then 50% Coinsurance
Physician visits during inpatient stay	Deductible then 100%	100%	Deductible then 10% Coinsurance	Deductible then 50% Coinsurance
Well Baby and Child Care including immunizations and inoculations	100%	100%	100%	Deductible then 50% Coinsurance
Annual Adult Physical	100%	100%	100%	Deductible then 50% Coinsurance
Annual Gynecological Exam	100%	100%	100%	Deductible then 50% Coinsurance
Primary Care Physician Requirement	Not Required	Not Required	Not Required	
PCP Referral	Not Required	Not Required	Not Required	
National Network	Yes	Yes	Yes	
Prior Authorization	Required by member	Required by member	Required by member	
Hospital Services				
Inpatient Hospital (semi-private room, anesthesia, x-ray, lab tests, etc)	Deductible then 20% coinsurance	$1,000 copayment	Deductible then 10% coinsurance	Deductible then 50% coinsurance
Outpatient Surgery	Deductible then 20% coinsurance	$200 copayment	Deductible then 10% coinsurance	Deductible then 50% coinsurance

Diagnostic Testing	EPO 25 In network only	EPO $30-$50 In network only	High Deductible PPO In network	 Out of network
Outpatient Hospital Laboratory Services:	$25 Copayment. No deductible	$50 Copayment	Deductible then 10% Coinsurance	Deductible then 50% coinsurance
Outpatient Hospital Radiology Services	$25 Copayment. No deductible	$50 Copayment	Deductible then 10% Coinsurance	Deductible then 50% coinsurance
Office Based Laboratory Services	$25 Copayment. No deductible	$50 Copayment	Deductible then 10% Coinsurance	Deductible then 50% coinsurance
Office Based Radiology Services:	$25 Copayment. No deductible	$50 Copayment	Deductible then 10% Coinsurance	Deductible then 50% coinsurance
Mammogram	100%	100%	100%	Deductible then 50% coinsurance
Cytology Screening	100%	100%	100%	Deductible then 50% coinsurance
Prostate Cancer Screening	100%	100%	100%	Deductible then 50% coinsurance
Maternity				
Inpatient Physician Services	Deductible then 100%	100%	Deductible Then 10% Coinsurance	Deductible then 50% coinsurance
Inpatient Hospital Services	Deductible then 20 % Coinsurance	$1,000 Copayment	Deductible Then 10% Coinsurance	Deductible then 50% coinsurance
Newborn Nursery	Deductible then 100%	100%	Deductible Then Covered in Full	Deductible then 50% coinsurance
Emergency Care				
Worldwide Emergency Care	Deductible Then 20% Coinsurance	$100 Copayment	Deductible Then 10% Coinsurance	All Emergency Care Is Considered In Network
Ambulance	Deductible then 20% Coinsurance	$100 Copayment	Deductible Then 10% Coinsurance	All Emergency Care Is Considered In Network
Urgent Care	$35 copayment. Not subject to deductible	$40 Copayment	Deductible Then 10% Coinsurance	Deductible then 50% coinsurance
Other Services				
Physical Therapy	$25 copayment. Not subject to deductible. Thirty (30) visits per benefit period)	$50 Copayment. Thirty (30) visits per benefit period)	Deductible Then 10% Coinsurance. Thirty (30) visits per benefit period)	Deductible then 50% coinsurance
Speech Therapy	Not Covered. Twenty visits per benefit period.	$50 Copayment. Twenty visits per benefit period.	Not Covered. Twenty visits per benefit period.	Not Covered
Occupational Therapy	$25 copayment. Not subject to deductible. Thirty (30) visits per benefit period)	$50 Copayment. Thirty (30) visits per benefit period)	Deductible then 10% Coinsurance. Thirty (30) visits per benefit period)	Deductible then 50% coinsurance
Chiropractic Benefits	$25 copayment. Not subject to deductible	$50 Copayment	Deductible then 10% Coinsurance	Deductible then 50% coinsurance
Home Health Care (if deductible, maximum is $50)	Deductible ($50) Then 20% Coinsurance	Covered In Full	Deductible Then 10% Coinsurance	Deductible then 50% coinsurance
Skilled Nursing Facility (Rider included that covers SNF for 365 days)	Deductible then 20% coinsurance	$1,000 Copayment. (365 Days: One time copayment)	Deductible then 10% coinsurance	Deductible then 50% coinsurance
Prosthetic Devices and Durable Medical Equipment	50% Coinsurance. No deductible. $25k lifetime cap	50% Coinsurance. No deductible. $25k lifetime cap	50% Coinsurance. No deductible. $25k lifetime cap	Covered in network only

Diabetic Care	EPO $25 In network only	EPO $30-$50 In network only	High Deductible PPO In network	 Out of network
Insulin and Oral Medications (30 day supply)	$15 Copayment	$15 Copayment	Deductible then $15 Copayment	Deductible then 50% coinsurance
Diabetic Supplies - 30 day supply of needles and syringes	$15 Copayment	$15 Copayment	Deductible then $15 Copayment	Deductible then 50% coinsurance
Glucose Meters	$15 Copayment	$15 Copayment	Deductible then $15 Copayment	Deductible then 50% coinsurance
Diabetic DME	$15 Copayment	$15 Copayment	Deductible then $15 Copayment	Deductible then 50% coinsurance
Mental Health				
Outpatient Mental Health Services	$25 copayment. Not subject to deductible	$50 Copayment	Deductible then 10% Coinsurance	Deductible then 50% coinsurance
Inpatient Mental Health services	Deductible then 20% Coinsurance	$1,000 Copayment	Deductible then 10% Coinsurance	Deductible then 50% coinsurance
Chemical Abuse and Dependency				
Outpatient Services	$25 copayment. Not subject to deductible	$30 Copayment	Deductible then 10% Coinsurance	Deductible then 50% coinsurance
Inpatient Detox. Svcs. (7 Days)	Deductible then 20% coinsurance	$1,000 Copayment	Deductible then 10% Coinsurance	Deductible then 50% coinsurance
Inpatient Rehab Svcs. (30 Days)	Deductible then 20% coinsurance	$1,000 Copayment	Deductible then 10% Coinsurance	Deductible then 50% coinsurance
Dependent and Domestic Partner Coverage				
Domestic Partner	Coverage is provided for eligible same or opposite sex domestic partner and his or her eligible children for all plans.			
Age Limits for students and dependants	Dependants to 23 and full time students to age 25, including out-of area coverage of prior approved, non routine covered services	Dependants to 23 and full time students to age 25, including out-of area coverage of prior approved, non routine covered services	Full time students to age 25	
Vision Coverage				
Hardware and Routine Eye Exam Every 24 Months commencing on the group effective date (Low Opt: $75 Frames & Lenses/$75 Contract Lenses)			N/A	
Pharmacy Coverage				
Rider name	EPRXS22A10	EPRXS55A10	HDRXS19A10	
Description	$4 co pay for generic 50% Brand w/ no max , 90 day mail order 2.5 times co pay, contraceptives covered	$10/$40/$80 With $3000 Max (Tier 1 & Mail Order Carved Out of Max)	Pharmacy co pay is 50%, open formulary, 90 day supply for 2.5 times regular monthly co pay, contraceptives included	

This benefit summary is for comparison purposed only. TERMS OF THE CONTRACT PREVAIL IN THE EVENT OF INCONSISTENCIES.