

## Canandaigua Chamber of Commerce

	Blue Choice Value	Blue Choice 25	BlueEPO Balance Option 5	BlueEPO Balance Option 6	Blue Healthy Choices Fit & Healthy	Blue Healthy Choices Healthy Family
<b>Plan Features</b>					Fit/Healthy Lifestyle Benefits - \$300 annual maximum per family toward avm membership. Lasik eye surgery, teeth whitening, toddler avm and swim programs and drivers education	Healthy Family Lifestyle Benefits - \$100 annual maximum per family toward avm membership. Lasik eye surgery, teeth whitening, toddler avm and swim programs and drivers education
<b>Primary Care Physician (PCP)</b>	Required	Required	Not required	Not required	Not Required	Not Required
<b>Referrals</b>	Required	Required	Not required	Not required	Not Required	Not Required
<b>Out of network benefits</b>	Not covered	Not covered	Not covered	Not covered	None	None
<b>Out of area benefits</b>	Emergency coverage provided worldwide through the BlueCard® program.	Emergency coverage provided worldwide through the BlueCard® program.	Coverage provided worldwide through the BlueCard® program.	Coverage provided worldwide through the BlueCard® program.	Coverage provided worldwide through the BlueCard® program.	Coverage provided worldwide through the BlueCard® program.

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<b>Student/ Dependent coverage</b>	Qualified students and dependents covered to age 26.	Qualified dependents covered 19. Students covered to age 26.	Qualified students and dependents covered to age 26.	Qualified students and dependents covered to age 26.	Qualified students and dependents covered to age 26.	Qualified students and dependents covered to age 26.
<b>Plan Cost Sharing Highlights</b>						
<b>Office visit copay (PCP)</b>	\$20	\$25	\$20	\$25	\$10	Adults - \$15 Kids to 19 - \$0
<b>Office visit copay (Specialist)</b>	\$20	\$40	\$20	\$25	\$20	\$20
<b>Coinsurance</b>	None	None	None	None	None	None
<b>Deductible</b>	None	None	None	None	None	None
<b>Out of pocket maximum</b>	None	None	None	None	None	None

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<b>Lifetime maximum</b>	None	None	None	None	None	None
<b>Plan Benefits</b>						
<b><u>Preventive Healthcare Services</u></b>						
<b>Well child visits</b>	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
<b>Adult routine physical exams</b>	\$20 copay	\$25 copay	\$20 copay	\$25 copay	\$10 copay	\$15 copay
<b>Adult immunizations</b>	\$20 copay	\$25 copay	Not Covered	Not Covered	\$20 copay	\$20 copay
<b>Mammography</b>	\$20 copay	\$25 copay	Covered in full	Covered in full	Covered in full	Covered in full
<b>Pap smear</b>	\$20 copay	\$25 copay	Covered in full	Covered in full	Covered in full	Covered in full
<b>Routine GYN Exam</b>	\$20 copay	\$25 copay	Covered in full	Covered in full	Covered in full	Covered in full

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<b>Prostate cancer screening</b>	\$20 copay	\$25 copay	Covered in full	Covered in full	\$10 copay	\$15 copay
<b>Routine vision</b>	\$20 copay for one routine eye exam every 2 years; every year for children to 19. \$60 eyewear allowance once every 2 years; every year for children to 19	\$40 copay for one routine eye exam every 2 years; every year for children to 19. \$60 eyewear allowance once every 2 years; every year for children to 19.	\$20 copay for one routine eye exam every 2 years. \$60 eyewear allowance once every 2 years.	\$25 copay for one routine eye exam every 2 years. \$60 eyewear allowance once every 2 years.	\$10 copay for one routine eye exam every year; \$20 copay for children to age 19. \$60 eyewear allowance every 2 years for adults, every year for children to age 19.	\$15 copay for one routine eye exam every year; \$0 copay for children to age 19. \$60 eyewear allowance every 2 years for adults. \$160 eyewear allowance for children to age 19.

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<b><u>Physicians Office Services</u></b>						
<b>Diagnostic office visits</b>	\$20 copay	\$25 PCP copay/\$40 specialist copay	\$20 copay	\$25 copay	PCP: \$10 copay Specialist: \$20 copay	PCP: Adults: \$15 copay Kids to 19: \$0 copay Specialist: \$20 copay
<b>Diagnostic x-rays</b>	\$20 copay	\$40 copay	\$20 copay	\$25 copay	\$20 copay	\$20 copay
<b>Diagnostic laboratory and pathology</b>	Covered in full	\$25 copay	Covered in full	Covered in full	Covered in full	Covered in full
<b>Allergy tests</b>	\$20 copay	\$25 PCP copay/\$40 specialist copay	\$20 copay	\$25 copay	PCP: \$10 copay Specialist: \$20 copay	PCP: Adults: \$15 copay Kids to 19: \$0 copay Specialist: \$20 copay

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<b>Allergy injections</b>	\$20 copay	\$25 PCP copay/\$40 specialist copay	\$20 copay	\$25 copay	PCP: \$10 copay Specialist: \$20 copay	PCP: Adults: \$15 copay Kids to 19: \$0 copay Specialist: \$20 copay
<b>Chemotherapy</b>	IV/Injectable chemotherapy will be covered with a \$20 copay on the drug, in addition to a \$20 office visit copay	IV/Injectable chemotherapy will be covered with a \$25 copay on the drug, in addition to a \$25 office visit copay	Covered in full	Covered in full	IV/injectable chemotherapy will be covered with a \$10 copay on the drug, in addition to a \$10 office visit copay.	IV/injectable chemotherapy will be covered with a \$15 copay on the drug, in addition to a \$15 office visit copay.
<b>Radiation therapy</b>	\$20 copay	\$25 copay	Covered in full	Covered in full	\$20 copay	\$20 copay

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<b><u>Maternity Services</u></b>						
<b>Prenatal and postpartum care</b>	\$5 copay for the first 10 visits, remainder covered in full.	\$5 copay for the first 10 visits, remainder covered in full.	\$20 copay	\$25 copay	\$10 copay for the first 10 visits, remainder covered in full	Covered in full
<b>Hospital care for mom (including delivery)</b>	<b>Facility:</b> Covered in full after a \$100 copay. <b>Physician:</b> 20% coinsurance or a \$100 copay, whichever is less.	<b>Facility:</b> Covered in full after a \$500 copay <b>Physician:</b> 20% coinsurance or \$200 copay, whichever is less	Covered in full after a \$250 copay.	Covered in full after a \$250 copay.	<b>Facility:</b> Covered in full after a \$250 copay. <b>Delivery:</b> 20% coinsurance or \$200 copay, whichever is less	<b>Facility:</b> Covered in full <b>Physician:</b> Covered in full
<b>Newborn nursery care</b>	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full

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<p><b><u>Prescription Drug</u></b></p> <p>Short-term and maintenance drugs are covered under the following copayments for each 30 day supply per prescription at participating retail pharmacies, up to a 90-day supply (with separate copays for each 30-day supply) available through Express Scripts, Inc., mail order service. Contraceptives included.</p>	<p>Retail and Mail Order: \$10/\$25/\$40</p> <p>IV/Injectable drugs will be covered with a \$20 copay on the drug, in addition to a \$20 office visit copay</p>	<p>Retail and Mail Order: \$ 7 Generic only</p> <p>IV/Injectable drugs will be covered with a PCP/Specialist copay on the drug, in addition to a PCP/Specialist office visit copay</p>	<p>Retail and Mail Order options available: \$10/\$25/\$40 w/ \$0 generic for kids to age 19</p>	<p>Retail and Mail Order options available: \$10/\$25/\$40 w/ \$0 generic for kids to age 19</p>	<p>Retail and Mail Order: \$10/\$30/\$50</p> <p>IV/ injectable drugs will be covered with a PCP/Specialist copay on the drug, in addition to a PCP/Specialist copay for the visit.</p>	<p>Retail and Mail Order: \$10/\$30/\$50</p> <p>IV/ injectable drugs will be covered with a PCP/Specialist copay on the drug, in addition to a PCP/Specialist copay for the visit.</p>

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<b><u>Inpatient Hospital Benefits</u></b>						
<b>Hospital benefits</b>	Covered in full after a \$100 copay.	Covered in full after a \$500 copay	Covered in full after a \$250 copay for unlimited days of room and board.	Covered in full after a \$250 copay for unlimited days of room and board.	Covered in full after a \$250 copay	Covered in full after a \$250 copay
<b>Physician visits in the hospital</b>	Covered in full	Covered in full	Covered in full for unlimited visits.	Covered in full for unlimited visits.	Covered in full	Covered in full
<b>Inpatient Physical Rehabilitation</b>	Covered in full after a \$100 copay for up to 60 days per calendar year.	Covered in full after a \$500 copay for up to 60 days per calendar year.	Covered in full after a \$250 copay for up to 60 days per calendar year.	Covered in full after a \$250 copay for up to 60 days per calendar year.	Covered in full after a \$250 copay for up to 60 days	Covered in full after a \$250 copay for up to 60 days

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<b>Surgery</b>	20% coinsurance or a \$100 copay, whichever is less	20% coinsurance or \$200 copay, whichever is less.	Covered in full	Covered in full	20% coinsurance or a \$200 copay, whichever is less	20% coinsurance or a \$200 copay, whichever is less
<b>Anesthesia</b>	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
<b><u>Emergency Care</u></b>						
<b>Emergency room care</b>	\$50 copay per visit unless admitted within 24 hours	\$100 copay per visit unless admitted within 24 hours.	\$50 copay per visit unless admitted within 24 hours.	\$50 copay per visit unless admitted within 24 hours.	\$50 copay per visit unless admitted within 24 hours	\$50 copay per visit unless admitted within 24 hours
<b>Freestanding urgent care center</b>	\$25 copay	\$35 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay

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<b>Ambulance (Ground)</b>	\$50 copay for emergency transportation.	\$100 copay for emergency transportation.	\$50 copay	\$50 copay	\$50 copay for emergency transportation	\$50 copay for emergency transportation
<b><u>Outpatient Hospital Benefits</u></b>						
<b>Diagnostic x-rays</b>	\$20 copay	\$40 copay	\$20 copay	\$25 copay	\$20 copay	\$20 copay
<b>Diagnostic laboratory and pathology</b>	Covered in full	\$25 copay	\$20 copay	\$25 copay	Covered in full	Covered in full
<b>Surgical Care</b>	Physician: \$20 copay Facility: \$50 copay	Facility: \$75 copay Physician: 20% coinsurance or a \$200 copay, whichever is less.	\$50 copay	\$50 copay	Facility: \$75 copay Physician: Covered in full	Facility: \$75 copay Physician: Covered in full

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<b>Chemotherapy</b>	IV/Injectable chemotherapy will be covered with a \$20 copay on the drug, in addition to a \$20 office visit copay	IV/Injectable chemotherapy will be covered with a \$25 copay on the drug, in addition to a \$25 office visit copay	Covered in full	Covered in full	IV/injectable chemotherapy will be covered with a \$10 copay on the drug, in addition to a \$10 visit copay.	IV/injectable chemotherapy will be covered with a \$15 copay on the drug, in addition to a \$15 visit copay.
<b>Radiation Therapy</b>	\$20 copay	\$25 copay	Covered in full	Covered in full	\$20 copay	\$20 copay
<b><u>Mental Health and Chemical Dependence Benefits</u></b>						
<b>Inpatient mental health care</b>	Covered in full after a \$100 copay for up to 30 days per calendar year.	Covered in full after a \$500 copay for up to 30 days per calendar year.	Covered in full after a \$250 copay for up to 30 days per calendar year.	Covered in full after a \$250 copay for up to 30 days per calendar year.	Covered in full after a \$250 copay for up to 30 days per calendar year	Covered in full after a \$250 copay for up to 30 days per calendar year

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<b>Outpatient mental health care</b>	\$20 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider's office	\$40 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider's office.	\$20 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider's office.	\$25 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider's office.	\$20 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider's office.	\$20 copay for up to 20 visits per calendar year. Services can be provided in an outpatient facility or in a provider's office.
<b>Inpatient chemical dependence care</b>	Covered in full after a \$100 copay for up to 7 days per calendar year for detoxification only.	Not Covered	Covered in full after a \$250 copay for up to 7 days per calendar year for detoxification and 30 days per calendar year for rehabilitation.	Covered in full after a \$250 copay for up to 7 days per calendar year for detoxification and 30 days per calendar year for rehabilitation.	Covered in full after a \$250 copay for up to 7 days per calendar year for detoxification only.	Covered in full after a \$250 copay for up to 7 days per calendar year for detoxification only.

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<b>Outpatient chemical dependence care</b>	\$20 copay for up to 60 visits per calendar year	\$25 copay for up to 60 visits per calendar year.	\$20 copay for up to 60 visits per calendar year.	\$25 copay for up to 60 visits per calendar year.	\$10 copay for up to 60 visits per calendar year	\$15 copay for up to 60 visits per calendar year
<b><u>Other Services</u></b>						
<b>Diabetic insulin &amp; supplies</b>	\$20 copay for a 30-day supply	\$25 copay for a 30-day supply	\$20 copay for a 30-day supply	\$25 copay for a 30-day supply	\$10 copay for a 30-day supply	\$15 copay for a 30-day supply
<b>Skilled nursing facility</b>	Covered in full after a \$100 copay for up to 120 days per calendar year. 360 day lifetime maximum.	Covered in full after a \$500 copay for up to 45 days per calendar year. 360 day lifetime maximum	Covered in full after a \$250 copay for up to 120 days per calendar year.	Covered in full after a \$250 copay for up to 120 days per calendar year.	Covered in full after a \$250 copay for up to 45 days per calendar year. 360 day lifetime maximum.	Covered in full after a \$250 copay for up to 45 days per calendar year. 360 day lifetime maximum.
<b>Home care</b>	Covered in full for unlimited visits	Covered in full for up to 40 visits per calendar year.	Covered in full for unlimited visits.	Covered in full for unlimited visits.	Covered in full for up to 40 visits per calendar year.	Covered in full for up to 40 visits per calendar year.

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<b>Hospice</b>	Covered in full for unlimited visits	Not Covered	Covered in full for unlimited days.	Covered in full for unlimited days.	Covered in full after a \$250 copay for up to 210 days.	Covered in full after a \$250 copay for up to 210 days.
<b>Outpatient therapy</b>	\$20 copay for up to 30 visits for physical, speech, occupational and respiratory therapy combined	\$40 copay for up to 30 visits for physical, speech, occupational and respiratory therapy combined.	\$20 copay for up to 40 visits for physical, speech, occupational and respiratory therapy combined.	\$25 copay for up to 40 visits for physical, speech, occupational and respiratory therapy combined.	\$20 copay for up to 30 combined visits for physical, speech and occupational therapy.	\$20 copay for up to 30 combined visits for physical, speech and occupational therapy.
<b>Durable medical equipment</b>	Covered at 50% up to a \$5,000 maximum per calendar year.	Not Covered	Covered at 80%	Covered at 80%	Covered at 50% up to a \$5,000 maximum per calendar year	Covered at 50% up to a \$5,000 maximum per calendar year
<b>External prosthetics</b>	Covered at 50% up to a \$15,000 maximum per calendar year.	Not Covered	Covered at 80% up to a \$15,000 maximum per calendar year.	Covered at 80% up to a \$15,000 maximum per calendar year.	Covered at 50% up to a \$15,000 maximum per calendar year	Covered at 50% up to a \$15,000 maximum per calendar year
<b>Chiropractic</b>	\$20 copay	\$40 copay	\$20 copay	\$25 copay	\$20 copay	\$20 copay

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<b>Acupuncture</b>	Covered at 50% for up to 10 visits per calendar year.	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Dental</b>	\$20 copay for accidental injury to sound natural teeth	\$40 copay for accidental injury to sound natural teeth.	\$20 copay for accidental injury to sound natural teeth.	\$25 copay for accidental injury to sound natural teeth.	\$20 copayment for accidental injury to sound and natural teeth and care due to congenital disease or anomaly	\$20 copayment for accidental injury to sound and natural teeth and care due to congenital disease or anomaly

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<b>Hearing</b>	\$20 copay for diagnostic hearing exams. \$600 hearing aid allowance once every 3 years for children to age 19.	\$40 copay for diagnostic hearing exams. \$600 hearing aid allowance once every 3 years for children to age 19.	\$20 copay for diagnostic hearing exams.	\$25 copay for diagnostic hearing exams.	\$10 PCP copay or \$20 specialist copay for diagnostic hearing exams. Hearing aids not covered.	\$15 PCP or \$20 specialist copay for adults and \$0 PCP copay or \$20 specialist copay for children to age 19 for diagnostic hearing exams. \$600 hearing aid allowance once every 3 years for children to age 19