



Capital Region BOCES Health Plan Summary - January 2009

	BlueShield Plan Community Blue HMO 202 / 202 +	CDPHP Plan AvidCare 10	MVP Plan HMO 10+	NYSHIP \$20 Copay In-Network No Deductible/ No Co-Insurance
Physician Services				
Primary Care	\$10 / \$0 or \$5	\$10	\$10	\$20
Specialist Care	\$10 / \$20 or \$15	\$10	\$10	\$20
Well baby, Child Care & Immunizations	\$0	\$0	\$0	\$0
Adult Annual Exam	\$10 / \$0 or \$5	\$0 Preventive	\$10	\$20
OBGYN Annual Exam	\$10 / \$0 or \$5	\$0 Preventive	\$10	\$20
Hospital Services				
Inpatient Hospital	\$0	\$0	\$0	\$0
Outpatient Surgery	\$10 / \$20 or \$15	\$75	\$10	\$35
Diagnostic Testing				
Laboratory Services	\$0	\$10 (waived if preferred provider is used)	\$0	\$20 at participating labs
Radiology/Imaging Services	\$0	\$10 (waived if preferred provider is used)	\$10	\$20 at participating provider
Maternity				
Physician Services	\$10 / \$20 or \$15	\$10 first visit / \$0 following visits	\$10 first visit / \$0 following visits	\$0
Inpatient Services	\$0	\$0	\$0	\$0
Emergency Care				
Emergency Room Care	\$35 (waived if admitted)	\$50 (waived if admitted)	\$35 In-area waived if admitted / \$0 out-of-area	\$60(waived if admitted)
Urgent Care Facility	\$10/ \$0 or \$5	\$25	\$10	\$20
Ambulance	\$0 (if medically necessary)	\$50	\$0	\$35
Chiropractic Benefits	\$10	\$10 - referral necessary	\$10	\$20
Mental Health				
Inpatient Care	\$0 - 30 days/year	\$0 I/P if medical - 30 days / yr	\$0 I/P / \$0 I/P Dr. 30 day max.	\$0
Outpatient Care	\$10/\$20 or \$15 (20 Visits Yr.)	\$10 (20 Visits Yr.)	\$10 (20 Visits Yr.)	\$20
Chemical Abuse/Dependency				
Inpatient Detoxification	\$0 - 30 days	\$0 (7 days per yr)	\$0 (7 days per yr)	\$0: 3 stays lifetime
Outpatient Rehabilitation	\$10 / \$20 or \$15 (60visits/yr)	\$10 (60 Visits Yr.)	\$10 (60 Visits Yr.)	\$20
Physical Therapy	\$10 / \$20 or \$15 (20vsts/condition)	\$10 - 120 visits per yr	Combined with Speech/Occ	\$20
Speech/Occupational Therapy	\$10 / \$20 or \$15 (20vsts/combined)	\$10 - 60 / 120 visits per yr	\$10 - 30 visit combined total	\$20
Home Health Care	\$0 (365 days/yr)	\$0 Pre-Authorized	\$10 - 60 visit max/yr	\$0 - Home Care Advocacy Program
Lifetime Maximum (In Network)	No maximum	No Maximum	No Maximum	No Maximum
Dependent Eligibility				
Dependent/ Student Age to:	19 / 25	19/25	19 / 25	19/25
Durable Medical Equipment	20% coinsurance	20% coinsurance	\$0	\$0 - Home Care Advocacy Program
Diabetic Drugs & Supplies	\$10 / \$0 or \$5	\$10	\$10	\$0 - Home Care Advocacy Program
Miscellaneous				
Vision Exam	\$10 (2 yrs) / \$20 or \$15 (1 yr)	\$10 (2 yrs)	Not Covered	Not Covered
Dental (Exam & Cleaning) 1X/Yr	HMO 202+ only - \$20 or \$15	Not Covered	Preventative Dental for dependents to 19	Not Covered
Out of Network Coverage	HMO 202+ only	Not Covered	Not Covered	Basic Medical (Provider Services)
Annual Deductible	\$250 / \$500	----	----	\$350 enrollee / \$350 spouse / \$350 children
Coinsurance	80% / 20%	----	----	80%UCR to \$1,000 ea person(3agg)/then100% covered
Annual Out-of-Pocket Max	\$5,000	----	----	\$3,000
Annual Maximum	\$250,000	----	----	None
				Hospital 10% co-ins. Max \$1,500 ea. Person(3 agg)
Prescription Drug *	Covered through Systemed Rx	Covered through Systemed Rx	Covered through Systemed Rx	Covered through NYSHIP Rx

* Systemed/Medco Rx will be the Drug Option for the HMO plans. NYSHIP Drug Option is through Medco but is completely separate from the HMO Medco plan. All RX options are outlined on the back of this comparison.

This is a summary of covered benefits and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply. Please refer to the complete contract or group plan issued upon enrollment. Prepared by Bouchey & Clarke Benefits, Inc. 2007



Bouchey & Clarke Benefits, Inc.

Systemed Medco Rx

(Prescription drug plan for employees using BS Community Blue(HMO), CDPHP or MVP)
This information is an overview of your prescription drug benefit through Systemed Medco.

Up to a 30 day supply from a participating retail pharmacy	
Generic Drug.....	\$5
Brand-Name Drug.....	\$10
*No differentiation between preferred and non-preferred drugs.	

Up to a 90 day supply through Medco Mail Service.	
Generic Drug.....	\$10
Brand-Name Drug.....	\$20
* No differentiation between preferred and non-preferred drugs.	

- * This plan may be used as a primary prescription drug program for all eligible family members. No Coordination of Benefits necessary.
- * Non-Participating Pharmacy: member must pay then submit for reimbursement.
- * Non-Participating Pharmacy: full cost of drug may not be covered.
- * For more information please visit the Systemed website at www.medco.com or call toll free at 1-800-711-0917
- * Medco Mail Service: no cost for shipping.

NYSHIP Medco Rx

This information is an overview of your prescription drug benefit.

You will have the following co-payments for drugs purchased from a participating pharmacy or through Medco Mail Service.

Up to a 30 day supply from a participating retail pharmacy or through the Medco Mail service	
Generic Drug.....	\$5
Preferred Brand-Name Drug	\$15
**Non-Preferred Brand-Name Drug.....	\$40

31 to 90 day supply from a participating retail pharmacy	
Generic Drug.....	\$10
Preferred Brand-Name Drug.....	\$30
**Non-Preferred Brand-Name Drug.....	\$70

31 to 90 day supply through the Medco Mail Service	
Generic Drug.....	\$5
Preferred Brand-Name Drug.....	\$20
**Non-Preferred Brand-Name Drug.....	\$65

- ** Change Effective January 1, 2009
- * Complementary and Alternative Medicine Program will be discontinued effective January 1, 2009
- * Non-Participating Pharmacy: member must pay then submit for reimbursement.
- * Non-Participating Pharmacy: cost of drug will be covered up to the amount the plan would reimburse to a participating pharmacy minus the co-pay.
- * For more information please visit the NYSHIP website at www.cs.state.ny.us or call toll free at 1-877-769-7447
- * Medco Mail Service: no cost for shipping.

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