



Capital Region BOCES Health Plan Summary* eff: January 2016

	Empire Prism Plan	New York State Health Insurance Plan (NYSHIP)
Physician Services		
Primary Care	\$10	\$20
Specialist Care	\$10	\$20
Well Baby, Child Care & Immunizations	\$0	\$0
Adult Annual Exam	\$0 Preventive	\$0 Preventive
OBGYN Annual Exam	\$0 Preventive	\$0 Preventive
Hospital Services		
Inpatient Hospital	\$0	\$0
Outpatient Surgery	\$10	\$60
Diagnostic Testing		
Laboratory Services	\$0	\$40 At Participating Labs
Radiology/Imaging Services	\$10	\$40 At Participating Providers
Maternity		
Physician Services	\$0	\$0
Inpatient Services	\$0	\$0
Emergency Care		
Emergency Room Care	\$35 (waived if admitted)	\$70 (waived if admitted)
Urgent Care Facility	\$10	\$20
Ambulance	\$0	\$35
Chiropractic Benefits	\$10	\$20
Mental Health		
Inpatient Care	\$0	\$0
Outpatient Care	\$10	\$20
Chemical Abuse/Dependency		
Inpatient Detoxification	\$0	\$0 (3 stays lifetime)
Outpatient Rehabilitation	\$10	\$20
Physical/Occupational Therapy	\$10 (120 days)	\$20
Speech Therapy	\$10 (60 days)	\$20
Home Health Care	\$0 (unlimited)	\$0 - Home Care Advocacy Program
Lifetime Maximum (In Network)	No Maximum	No Maximum
Durable Medical Equipment	20% coinsurance	\$0 - Home Care Advocacy Program
Diabetic Drugs & Supplies	\$10	\$0 - Home Care Advocacy Program
Miscellaneous		
Vision Exam	\$10 (one per year)	Not Covered
Out of Network Coverage		Basic Medical (Provider Services)
Annual Deductible		\$1,000 enrollee/\$1,000 spouse/\$1,000 all children comb.
Coinsurance		80%/20% UCR to \$3,000 enrollee/\$3,000 spouse/\$3,000 all children comb., then 100% UCR covered
Comb. Annual Coinsurance Out-of-Pocket Max		\$3,000 enrollee/\$3,000 spouse/\$3,000 all children comb.
Annual Maximum		None
Inpatient Hospital	Not Covered	10% of billed charges for inpatient facility services, until the combined annual coinsurance maximum is met. Network coverage is provided once the combined annual coinsurance maximum is satisfied. (Deductible & Coinsurance for Out of Network Physician Visits)
Outpatient Hospital Services	Not Covered	10% of billed charges or a \$75 copayment, whichever is greater, for outpatient services, until the combined annual coinsurance maximum is met. Network coverage is provided once the combined annual coinsurance maximum is satisfied. (Deductible & Coinsurance for Out of Network Physician Visits)
In Network Out of Pocket Max	Medical \$4,000/ \$8,000 Rx \$2,600 / \$5,200	Medical \$4,450 / \$8,900 Rx \$2,400 / \$4,800
Prescription Drug	Express Scripts (ESI)	CVS Caremark
Retail	\$5/\$10/\$10	\$5/\$25/\$45
90 Day at Retail	n/a	\$10/\$50/\$90
90 Day at Mail	\$10/\$20/\$20	\$5/\$50/\$90

*This is only a summary and does not detail all benefits, limitations and exclusions.

For a detailed Summary of Benefits Coverage for NYSHIP and the Empire Prism plan, visit the Open Enrollment link on the top right of the BOCES staff resources webpage located at: www.capitalregionboces.org/StaffResources.