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	Not Covered	Basic Medical (Provider Services)
Annual Deductible		$1,000 enrollee/$1,000 spouse/$1,000 all childen 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		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		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 providered 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.