Rochester City Schools **2011 Employer Group Retiree Plan-Renew** **Medicare Blue Choice HMO/POS Benefit Summary**	
MEDICAL BENEFITS	
Annual Deductible	None
Annual Out-of-Pocket Maximum	$3,400
Inpatient Care	
Inpatient Hospitalization (Includes inpatient mental health, chemical dependency and rehabilitation services)	$250, 2 max
Skilled Nursing Facility (Coverage for days 1 - 100)	$0 Day 1-20; 50% days 21-100
Physician Services	
Primary Care Physician (PCP) Office Visit	$15 Copay
Specialist Office Visit (includes urgent care visits)	$15 Copay
Chiropractor Office Visit (manual manipulation to correct subluxation)	$15 Copay
Podiatrist Office Visit (for medically necessary foot care)	$15 Copay
Outpatient Care	
Emergency Room (waived if admitted within 23 hours, worldwide coverage	$50 Copay
Urgent Care	$15 Copay
Ambulance	$50 Copay
Outpatient Mental Health	45% Coinsurance
Outpatient Chemical Dependency	50% Coinsurance
Diagnostic Tests and Laboratory Services	Covered in Full
Radiological Services (X-Ray, Chemotherapy)	$15 Copay
Outpatient Services/Surgery	$15 Copay
Rehabilitation Therapy (physical, occupational and speech)	$15 Copay
Cardiac Rehabilitation	$15 Copay
Durable Medical Equipment (DME) & Prosthetic Devices	20% Coinsurance
Home Health Care (Includes home infusion)	Covered in full
Diabetic Supplies	$15 Copay
Kidney Dialysis	Covered in Full
Medicare Part B Drugs Including Part B-Covered Chemotherapy Drugs	20% Coinsurance
Preventive Services (Office Visit Copay may apply)	
Routine Physical Exam	Covered in Full
Immunizations (Flu, Pneumonia, H1N1 and Hepatitis B vaccines)	Covered in Full
Mammograms	Covered in Full
Prostate Cancer Screening	Covered in Full
Bone Mass Measurement	Covered in Full
Pap Smears/Pelvic Exams	Covered in Full
Colorectal Screening	Covered in Full
Medicare Covered Preventive Services	
Medicare Covered Hearing Services (routine exam)	$15 Copay
Medicare Covered Vision Care(routine exam;eyeware post-cataract surgery)	$15 Copay

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Additional Coverage	
Hearing Aid Allowance - once every 3 calendar years	$300 allowance
Point of Service (POS) You may elect to receive covered services from out-of-network providers.	20% up to $5000
Fitness Benefit This fitness benefit covers health club membership and fitness classes; it is not limited to specific gyms. The benefit can also be used for qualified weight management programs. There are virtually no claim forms.	Go Getters ($650)
Annual Routine Eyewear Allowance	Optional Rider: $60 annual allowance

MEDICARE PART D PRESCRIPTION DRUG BENEFITS

Annual Deductible **$0.00**

Initial Coverage:

	30-Day Supply	90-Day Supply
Tier 1:	40% Coinsurance	40% coinsurance
Tier 2:	40% Coinsurance	40% coinsurance

Coverage Gap:

After total yearly out-of-pocket drug costs paid by both the member and the plan for Part D eligible drugs reach $3, 400, the members pays 93% for Tier 1 and Tier 4 generics, 100% for all other drugs, and receives a discount on eligible brand name drugs until total out-of-pocket costs reaches $4,550.

Catastrophic Coverage:

After yearly out-of-pocket drug costs paid by the member reach $4,550, the member pays the greater of $2.50 copayment for generic and a $6.30 copayment for all other drugs, or 5% coinsurance.

The benefit information provided is not comprehensive. Please consult your Evidence of Coverage for a detailed explanation of benefits and any applicable restrictions. To the extent of any discrepancy between this document and the Evidence of Coverage, the Evidence of Coverage terms take priority.

Care must be provided or authorized by a participating primary care physician for full HMO benefits, except in emergencies. The copayments are applied per provider per day except where specifically noted otherwise.

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