

Rochester City School District
2010 Employer Group Retiree Plan-Renew
Medicare Blue Choice HMO Benefit Summary

MEDICAL BENEFITS

Annual Deductible	None
Annual Out-of_Pocket Maximum	None

Inpatient Care

Inpatient Hospitalization (Includes inpatient mental health, chemical dependency and rehabilitation services)	\$250, 2 max
Skilled Nursing Facility	\$0/day, days 1-20; 50%/day, 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, respiratory and speech)	\$15 Copay
Cardiac Rehabilitation	\$15 Copay
Durable Medical Equipment (DME) Prosthetic Devices	20% Coinsurance
Home Health Care	Covered in full
Diabetic Supplies	\$15 Copay
Kidney Dialysis	Covered in Full
Medicare Prt B Drugs Including Part B-Covered Chemotherapy Drugs	20% Coinsurance

Preventive Services

Routine Physical Exam	Covered in Full
Immunizations (Flu, Pneumonia 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 Hearing Services (routine exam)	\$15 Copay
Medicare Covered Vision Care (routine exam; eyeware post-cataract surgery)	\$15 Copay
Medicare Covered Dental Services (preventive benefits not covered)	\$15 Copay



Additional Coverage

Annual Routine Eyewear (\$60 Annual Allowance)	Optional Rider: \$60 annual allowance
Hearing Aid Allowance - once every 3 calendar years	\$300 allowance
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	Go Getters (\$650)
Travel Benefit	20% up to \$5000

MEDICARE PART D PRESCRIPTION DRUG BENEFITS

Annual Deductible: \$0.00

Initial Coverage:

	<u>30-Day Supply</u>	<u>90-Day Supply</u>
Tier 1:	40% Coinsurance	40% coinsurance
Tier 2:	40% Coinsurance	40% coinsurance
Tier 3:	NA	NA
Tier 4:	NA	NA

Coverage Gap:

After total yearly out-of-pocket drug costs paid by both the member and the plan for Part D eligible drugs reaches \$3,250, the member pays 100% until total out-of-pocket costs reach \$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.

