DRAFT Comparison of Benefits for Benchmark Coverage for New York State

	Affordable Care Act	NEW YORK STATE PUBLIC HEALTH INSURANCE PROGRAMS						BENCHMARK PLANS					NEW YORK STATE HEALTH INSURANCE PLANS	
		Medicaid									Federal Employees BC/BS (Fee-for-Service)			
TYPE OF SERVICE	Essential Health Benefits[2]	Managed Care Non-SSI	Managed Care SSI	Fee-for-Service Carve Out	Straight Fee-for-Service	Family Health Plus	Child Health Plus	NY State Employees (M/C)	Individual Direct Pay HMO: Empire HealthChoice	HMO Group Coverage in NYS:	Basic Option	Standard Option	Healthy NY	NY Bridge Plan (Pre-Existing Conditions)
HOSPITAL BENEFITS														
Inpatient Services	✓	Covered, unless admit date precedes Effective Date of Enrollment	Covered, unless admit date precedes Effective Date of Enrollment	Stay covered only when admit date precedes Effective Date of Enrollment	Covered (conditions to be met?)	Covered, unless admit date precedes Effective Date of Enrollment	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered ($500 co-pay per admission)
Outpatient Services (MA) (Ambulatory Care)	✓	Covered	Covered	-	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered, $250 copay for ambulatory surgery facility
Emergency Medical Services (M)	✓	Covered	Covered	-	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Skilled Nursing Care Facility (MA)		Covered, except individuals in permanent placement	Covered, except individuals in permanent placement	-	Covered (conditions to be met?)	-	-	Covered 365 benefit days of care; each day in SNF counts as one-half benefit day. No coverage if Medicare Prime	Covered, when preceded by at least a 3 day hospital stay and further hospitalization would be necessary	Make Available	-	Limited secondary benefits, must have Medicare Part A; covers up to 30 days per each benefit period	-	Covered
Hospice (MA)		-	-	Covered	Covered	Covered	Covered	Covered (No limitations on length of stay)	Covered, 210 days Hospice, 5 visits bereavement	Make Available, 210 days Hospice, 5 visits bereavement	Covered	Covered	-	Covered, up to 210 days per lifetime
Therapy Treatments (MA) (may include chemo, radiation, renal dialysis)		Covered	Covered	-	Covered	Covered	Covered	Covered No copayment under Hospital or Medical Program for these services; no limitations.	Covered	Covered	Covered	Covered	Covered	Covered (special limits may apply to individuals w/ end-stage renal disease)
Second Medical/Surgical Opinion (M)		Covered	Covered	-	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered

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MEDICAL/SURGICAL BENEFITS														
Preventative & Primary Care: Adults (M) - Routine check-ups - Tests & procedures ordered by PCP - Immunizations	✓	Covered	Covered	-	Covered	Covered	N/A	Covered, limitations on immunizations	Covered	Covered	Covered	Covered	Covered, physical exam every 3 years	Covered
Preventative & Primary Care: Children (M) - Newborn Care - Pediatric Care - Immuzations/Vaccines - Routine check-ups	✓	Covered	Covered	-	Covered	C/THP services are only available to 19 & 20 year olds	Covered	Covered, immunizations covered to age 19	Covered	Covered	Covered Routine services -physical exam, hearing tests, lab tests, immunizations & vaccines, etc., up to age 22 (co-payments/co-insurance n/a)		Covered	Covered
Chronic Disease Management	✓	Covered	Covered	-	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Maternity Care (M)	✓	Covered	Covered	-	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Diagnostic Laboratory Services (MA)	✓	Covered	Covered	HIV phenotypic, virtual phenotypic and genotypic drug resistance tests and viral tropism testing	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Radiology & Imaging Services (MA)	✓	Covered	Covered	-	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Durable Medical Equipment	✓	Covered	Covered	-	Covered	Covered	Covered	Covered, precertification required	Covered	Optional, limits permitted	Covered	Covered	-	Covered, Precert required if amt over $2000
Prostheses & Orthotic Devices (POD)	✓	Covered	Covered	-	Covered	Covered, except orthopedic shoes	Covered	Covered	Covered	Optional limits permitted	Covered	Covered	Limited to post-mastectomy breast prostheses	Covered
Rehabilitation Services (MA) (may include physical therapy, occupational therapy and/or speech therapy)	✓	Covered Limited to 20 visits per therapy per calendar year effective Oct '11,except for children & the developmentally disabled	Covered	-	Covered	Covered, short term inpatient; & limited to 20 visits for outpatient physical & occupational therapy per calendar year. Eff Oct '11, speech therapy will be limited to 20 visits per calendar year	Covered, for short term inpatient; & short term Phy/Occupational Therapy	Covered, precertification required	Covered, outpatient physical therapy 90 visits per condition per calendar year	Make Available Physical Therapy & Occupational Therapy (visit limits are permitted)	Covered, limited to 50 visits per person, per calendary year	Covered, limited to 75 visits per person, per calendary year	Covered, up to 30 post-hospital or post-surgical physical therapy visits; Occup & Speech therapy NOT covered	Covered, for up to 30 visits for Physical/ Occupational Therapy; Speech therapy up to 10 visits

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MENTAL HEALTH/SUBSTANCE ABUSE	✓													
Mental Health Treatment Services														
- Inpatient Services (M)		Covered	-	Covered for SSI recipients	Covered	Covered, limited to 30 days combined w/ chemical dependency services	Covered	Covered, when medically necessary	Covered, 30 days per calendar year offset by inpatient chemical dependence	Sm Group **(M)** 30 days **(MA)**Full Parity (see comment box) Lrg Group **(M)**Full Parity w/ no visit limits	Covered	Covered	-	Covered, 30 days per calendar year
- Outpatient Services (M)		Covered	-	Covered for SSI recipients	Covered	Covered, limited to 60 days combined w/ chemical dependency services	Covered	Covered, when medically necessary	Covered, 30 nonemergency & 3 emergency visits per calendar year	Sm Group **(M)** 20 visits **(MA)** Full Parity (see comment box) Lrg Group **(M)**Full Parity w/ no visit limits	Covered, Requires prior approval-BC/BS will advise # of visits initially approved.		-	Covered, limited to 30 days; no limits for biologically based mental illnesses
Chemical Dependence Services														
- Inpatient Services (**M** for large group, **MA** for small group)		Covered, subject to stop loss	-	Covered for SSI recipients	Covered	Covered, limited to 30 days combined w/ mental health services	Covered	Covered, when medically necessary	Covered, detox only 30 days per calendar year offset by inpatient mental health	Sm Group **(MA)** 30 days Lrg Group **(M)** Full Parity w/ no visit limits	Covered	Covered	-	Covered, limited to 30 days
- Outpatient Services (M)		-	-	Covered	Covered	Covered, limited to 60 visits combined w/ mental health services	Covered	Covered, when medically necessary	-	Sm Group **(M)** 60 visits Lrg Group **(M)** Full Parity w/ no visit limits	Covered, Requires prior approval-BC/BS will advise # of visits initially approved.		-	Covered, limited to 60 visit; up to 20 family visits
Detoxification Services														
- Inpatient Services (**M** for large group, **MA** for small group)		Covered	Covered	-	Covered	Covered	Covered	Covered, when medically necessary under the hospital benefit	Covered, detox only 30 days per calendar year offset by inpatient mental health	Sm Group **(MA)** 7 days Lrg Group **(M)** Full Parity w/ no visit limits	Covered, Requires prior approval for inpatient		-	Covered, limited to 7 days
- Withdrawal Services (**M** for Outpatient) (**M** for large group inpatient) (**MA** small group inpatient)		Covered	Covered	-	Covered	Covered	Covered	Covered, when medically necessary under the hospital benefit	-	Sm Group **(MA)** Lrg Group **(M)** Full Parity w/ no visit limits	Covered, Requires prior approval for inpatient		-	Covered, included with inpatient & outpatient detox services

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PRESCRIPTION DRUG BENEFITS	✓													
- Prescription Drugs		Pharmaceuticals & medical supplies routinely furnished or administered as part of a clinic or office visit, except Risperdal Consta	Pharmaceuticals & medical supplies routinely furnished or administered as part of a clinic or office visit, except Risperdal Consta	Covered outpatient drugs from the list of Medicaid reimbursable prescription drugs, subject to any applicable co-payments	Covered	Covered through the Medicaid Program (includes prescription drugs, insulin & diabetic supplies, smoking cessation agents, select OTCs, hearing aid batteries & enteral formulas.)	Covered, Coverage of modified solid food products limited to 2500 per calendar year.	Covered Co-payments apply	Covered, prescription drugs & enteral formula	Optional	Covered, 3 levels of pymt; More flexible than Basic option; Higher level of benefits with a Preferred & Mail Service	Covered, 3 levels of pymt; Must use Preferred Pharmacy; Mail Service not available under this option	Available by Rider	Covered
- Enteral Formula (M, if prescription drugs covered)										Covered, when the prescription drug benefit is provided			Included in RX Rider	
- Non-Prescription Drugs								Not Covered except for insulin & oral agents	-	Optional	OTC Smoking cession drugs are covered	OTC Smoking cession drugs are covered	-	-
TRANSPORTATION SERVICES														
- Emergency Transportation (M)		Covered, if included in Contractor's Benefit Package This benefit will be covered under FFS-Carve Out (eff date TBD)	Covered, if included in Contractor's Benefit Package This benefit will be covered under FFS-Carve Out (eff date TBD)	Covered, if not included in Contractor's Benefit Package This benefit will be covered under FFS-Carve Out (eff date TBD)	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	-	Covered
- Non-Emergency Transportation		Covered, if included in Contractor's Benefit Package as per agreement. Eff Oct '11, benefit will be transitioned to FFS-Carve Out	Covered, if included in Contractor's Benefit Package as per agreement. Eff Oct '11, benefit will be transitioned to FFS-Carve Out	Covered, if not included in Contractor's Benefit Package Eff Oct '11, benefit will be covered under FFS-Carve Out, therefore will no longer be covered under the Contractor's benefit package	Covered	Not Covered, except for transportation to C/THP services for 19 & 20 year olds	-	Covered	Covered	Optional (limits permitted)	$100 copayment per day for ground ambulance transport services to or from nearest hospital	Limited, to transport serices to/from nearest hospital-full coverage if care is rec'd with, & w/in 72 hours after an accidental injury.	-	-
											Not Covered: Wheelchair van services & gurney van services			
VISION SERVICES	✓	(for children)												
- Vision services related to a specific medical condition (e.g., surgury for glaucoma)		Covered	Covered	-	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered (e.g., pink eye)	Covered
- Routine Vision Services (e.g., eye exam)								Covered by EyeMed (once every 24 months)	Covered for children under preventative care	Covered for children under preventative care	Not Covered under BC/BS, **However**, routine services & supplies can be obtained by enrolling in Federal Employees Dental/Vision Insurance Program (FEDVIP)		-	Covered, One eye exam every 24 months

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DENTAL SERVICES	✓	(for children)												
- Emergency Dental Services (e.g., treatment of accidental injuries to sound, natural teeth)		Covered, if included in Contractor's Benefit Package, except orthodontia	Covered, if included in Contractor's Benefit Package, except orthodontia	Covered, if not included in Contractor's Benefit Package	Covered	Covered, if included in Contractor's Benefit Package, except orthodontia	Covered, Medically necessary orthodontia services included.	Covered	Covered, with limitations	Covered, with limitations	Covered	Covered	Covered	Covered
- Routine Dental Services								Covered by GHI Subject to annual maximum of $2000 per covered member. Orthodontic Services are available only to enrolled dependent children under 19 years of age with a lifetime maximum per covered dependent of $1,998.	-	-	Covers Basic Dental, Must use Pref Provider (oral eval & preventative-2x per year & radiographs-1 complete intraoral every 3 years, bitewings-4 films per year)	Covered, Standard Option provides add'l routine services than the basic option. Orthodontic care not covered.	-	-
OTHER SERVICES														
Hearing Services (may include testing, treatment and supplies)		Covered, except for hearing aid batteries	Covered, except for hearing aid batteries	Hearing aid batteries	Covered	Covered, including hearing aid batteries	Covered, including hearing aid batteries	Covered, Adults-max allowance of $1500 per ear every 4 yrs & Children under 12-max $1500 per ear every 2 years	Routine tests for children covered under preventative care. Supplies covered if DME.	Optional, limits permitted Routine tests for children covered under preventative care.	Covered, if related to illness or injury Routine hearing tests are covered for children under preventative care. Hearing aids covered under POD for children up to age 22-limit $1000 per ear per calendar year & Adults-limit $1000 per ear per 36-month period		Routine tests covered for children under preventative care.	Limited, Hearing aids & examinations are **not** covered
Home Health Care Services (M)		Covered	Covered	-	Covered	Covered, for 40 visits in lieu of a skilled nursing facility stay or hospitalization, plus 2 post partum home visits for high risk women	Covered, for 40 visits (per calendar year) in lieu of a skilled nursing facility stay or hospitalization.	Covered, precertification required	Covered, 200 visits per calender year	Covered for 40 visits	Covered, limited to two (2) hours per day, up to 25 visits per calendar year; services must be provided by a R.N. or L.P.N	Covered, limited to two (2) hours per day, up to 25 visits per calendar year; services must be provided by a R.N. or L.P.N	Covered, up to 40 post hospital or post-surgical visits per calendar year	Covered, up to 200 visits per calendar year
Skilled Nursing Services		Covered	Covered	-	Covered	-	-	Covered, precertification required	Covers private duty nursing	Optional	-	-	-	Covered in a skilled nursing facility
Experimental and/or Investigational Treatment (M)		Covered, on a case by case basis	Covered, on a case by case basis	-	Covered, on a case by case basis	Covered, on a case by case basis	-	Covered, on a case by case basis	Covered, on a case by case basis, subject to external appeal	Covered, on a case by case basis, subject to external appeal	Not Covered, may be exceptions for transplants	Not Covered, may be exceptions for transplants	Covered, on a case by case basis, subject to external appeal	Not Covered, **unless** approved by an external appeal agent certified by NYS

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Chiropractic Services (M)		Covered, children under the age of 21 as per EPSDT program requirements when such services are ordered by a physician (Federal law at 42 CFR requires this coverage whether or not services are covered under the State plan)	Covered, children under the age of 21 as per EPSDT program requirements when such services are ordered by a physician (Federal law at 42 CFR requires this coverage whether or not services are covered under the State plan)	-	Covered benefit for the following conditions: children under the age of 21 as part of the EPSDT program only when ordered by a physician. Medicaid also pays the Medicare co-insurance and deductibles for dually eligible QMBs receiving chiropractic services.	-	-	Covered, precertification required	-	Covered	Covered, limited to one office visit, one set of X-rays & 20 manipulations per calendary year	Covered, limited to one office visit, one set of X-rays & 12 manipulations per calendary year	-	Covered
Infertility Services (M)														
- Diagnosis and treatment of infertility		-	-	-	-	-	-	Covered, with limitations	Covered, if treatment of a correctable medical condition	Covered, with limitations	Covered		-	Covered
- Assisted reproductive technology procedures									-		-			-
Family Planning/Reproductive Hlth Serv														
- Contraception (M, if prescription drugs covered or if contract is not grandfathered)		Covered, if included in Contractor's Benefit Package	Covered, if included in Contractor's Benefit Package	Covered, if not included in Contractor's Benefit Package	Covered	Covered, if included in Contractor's Benefit Package. If not, services will be covered through ta designated 3rd party contractor	Covered	Covered	Covered	Covered	Covered	Covered	-	Covered
- Voluntary sterilization							N/A	Covered	Covered, if contract is not grandfathered	Covered, if contract is not grandfathered	Covered	Covered	-	-
- Abortion (medically necessary)							Covered	Covered	Covered	Covered	Covered, when the life of the mother would be endangered if the fetus were carreid to term or when the pregnancy is the result of an act of rate or incest.		Covered, ($200 co-payment)	Covered, when life of mother would be endangered if fetus were carried to term or when the pregnancy is result of rate/incest
- HIV Testing & Counseling		Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Midwifery Services (M)		Covered	Covered	-	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Smoking Cessation Products		-	-	Covered (Benefit (i.e., counseling) expanded to all enrollees over age 9 who smoke effective Jun '11)	Covered	Covered, through the MFFS	Covered, if prescribed by a physician	Covered, if prescribed by a physician	Covered, if prescribed by a physician	Covered, when the prescription drug benefit is provided	Covered, Full covereage in 2011	Covered	Covered, under prescription rider	-

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Personal Care Services (PCS)		Covered, Effective 7/1/2011, PCS will be included in the Contractor's Benefit Package	Covered, Effective 7/1/2011, PCS will be included in the Contractor's Benefit Package	- Effective 7/1/11, PCS will no longer be carved out of the Contractor's benefit package	Covered	-	-	-	-	-	Defined as custodial care in contract; generally not covered, but can go through medical review	Defined as custodial care in contract; generally not covered, but can go through medical review	-	-
Foot Care Services														
- Foot Care related to a specific medical condition		Covered	Covered	-	Covered	Covered	Covered	Covered	Covered, with limitations	Covered, with limitations	Covered	Covered	Covered	Covered, up to 4 visits per calendar year
- Routine Foot Care Such as cutting, trimming, or removal of corns, calluses, and similar routine treatment of conditions of the foot.		-	-	-	-	-	-	-	-	permissible exclusion	-	-	-	-
Other Services (Misc)									Diabetic equipment, supplies & self management education. Blood & blood products	Diabetic equipment, supplies & self management education. Blood & blood products	Acupuncture (Alternative treatments) limited to 24 visits per calendar year	Acupuncture (Alternative treatments) Covered		
COST COMPONENT														
Per member per month (PMPM)		S/CCs (MA only Managed Care)* **$401.00**	Parents, including LTC: **$410.00** S/CC's, including FHP & LTC**: **$573.00** S/CCs, Medicaid only***: **$521.00**		**$321.00**♦ 08-09 Rates **$428.95** Avg of Jan '10 Rates Avg Cost of Wrap (included in PMPM?) **$84.98**	Weighted Average Rate: Sep '10: **$173.08** Dec '10: **$172.97** Mar '11: **$174.98** Jun '11: **$172.76**		Empire Plan Individual Plan **$696.08** 2011 Rate **$614.69** 2010 Rate Dental-Indiv **$30.25‡** Vision-Indiv **$4.27‡**	**UPSTATE NY** Individual: **$967.20** Husb/Wife: **$1,934.40** Parent/Child(ren): **$1,798.99** Family: **$2,998.32** **DOWNSTATE NY** Individual: **$1,289.61** Husb/wife: **$2,579.22** Parent/Child(ren): **$2,398.67** Family: **$3,997.79**	**HIP Prime for Small Groups** (2-50 Employees) **$?** **HIP Prime for Large Groups** (51+ Employees) **$?**	Basic Option Individual Plan 2010: **$403.04** 2011: **$453.48**	Standard Option Individual Plan 2010: **$538.24** 2011: **$578.61**	Avg Rate for NYC: with prescriptions- **$327.90** with/o prescriptions- **$288.18** Avg Rate for Albany: with prescriptions- **$282.78** with/o prescriptions- **$238.03**	Downstate NY Counties **$421.00**[1] Upstate NY Counties **$362.00**[1]
											Federal Employees Dental/Vision Insurance Program (FEDVIP) 2011 - Individual Vision **$8-14** 2011 - Individual Dental **$18-49** (Employee pays full premium-no monies from federal gov't)			

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◊ The "Essential Health Benefits" have not been fully defined at this time.

(M) Mandated benefits for inclusion in Group Commercial, HMO & Article 43 Insurance Contracts based on information from NYS Insurance Dept. (this is not an all-inclusive list).

(MA) Make Available benefits for inclusion in Group Commercial, HMO & Article 43 Insurance Contracts based on information from NYS Insurance Dept. (this is not an all-inclusive list). Please note some of the MA benefits are mandatory for HMO group coverage (i.e. to be deemed comprehensive) per NYS DOH requirements.

"-" [and shaded in gray]: Service(s) not covered and/or signficant limitations

? Insufficient information to determine if service(s) are covered under specified program/plan

* Data for Kaiser FHP presentation 6/10- based on MA Expenditure Data 2008 (Roohan, et al)

** Data Warehouse & DOH/OHIP AFPP DataMart (claims paid through March '10- MA Expenditures for 9 groups inc LTC SFY 09-10) (Hwang, Armstrong, Kang et al)

*** Data for Kaiser FHP presentation 6/10- based on MA Expenditure Data 2008 (Roohan, et al)

♦ FHP Updated PMPM Peter Gallagher

[1] PCIP is partially funded by the federal government - the amount shown is the enrollee's portion of the premium

PCP = Primary Care Provider (Physicain/Certified Nurse Practioner)

PW = Pregnant Women

Cost-sharing = the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

‡ Employer pays 100% for active employees - Rates reflect premium for employees on leave without pay that must pay full premium

◊ The "Essential Health Benefits" have been described to include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Mental health & substance use disorder services, including behavioral health services
- Pediatric services, including oral and vision care
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices

Smoking Cessation Counseling Benefit for Medicaid:

ONLY available to pregnant and postpartum women (up to six months postpartum); and to children and adolescents ages 10 through 20, who smoke.

- Pregnant women will be allowed six (6) counseling sessions during their pregnancy.
- Postpartum women will be allowed six (6) counseling sessions during the 6 month postpartum period.
- Children and adolescents ages 10 - 20 will be allowed up to six (6) counseling sessions in a continuous 12-month period.

NOTE: Smoking Cessation Counseling benefit will be expanded to all enrollees over the age of 9 who smoke starting June 1, 2011.

DRAFT - Empire Plan Copayments At A Glance - 2011

Medical/Surgical Program

Participating Provider Program

$20 Copayment - Office Visit, Office Surgery, Radiology, Diagnostic Laboratory Tests, Free-standing Cardiac Rehabilitation Center Visit, Urgent Care Visit

$30 Copayment - Non-hospital Outpatient Surgical Locations

$35 Copayment - Local Professional/Commercial Ambulance Transportation

Chiropractic Treatment or Physical Therapy Services (Managed Physical Medicine Program)

$20 Copayment - Office Visit, Radiology, Diagnostic Laboratory Tests

Hospital Services (Hospital Program)

$60 Copayment - Outpatient Surgery
$20 Copayment - Outpatient Physical Therapy
$40 Copayment - Outpatient Services for Diagnostic Radiology, Mammography Screening & Administration of Desferalfor Cooley's Anemia in a Network Hospital or Hospital Extension Clinic
$70 Copayment - Emergency Room Care

Mental Health and Substance Abuse Program

$20 Copayment - Visit to Outpatient Substance Abuse Treatment Program
$20 Copayment - Visit to Mental Health Professional
$70 Copayment - Emergency Room Care

Prescription Drug Program

Up to a 90-day supply from a participating retail pharmacy or mail service.

You have the following copayments for drugs purchased from a participating retail pharmacy or through Medco Pharmacy (mail service).

Up to a 30-day supply of a covered drug from a participating retail pharmacy or Medco Pharmacy

Level 1 or Generic Drug	$5
Level 2, Preferred Brand-Name Drug or Compound Drug	$15
Level 3 or Non-Preferred Brand-Name Drug	$40

31- to 90-day supply of a covered drug from a participating retail pharmacy

Level 1 or Generic Drug	$10
Level 2, Preferred Brand-Name Drug or Compound Drug	$30
Level 3 or Non-Preferred Brand-Name Drug	$70

31- to 90-day supply of a covered drug through the Medco Pharmacy

Level 1 or Generic Drug	$5
Level 2, Preferred Brand-Name Drug or Compound Drug	$20
Level 3 or Non-Preferred Brand-Name Drug	$65

If you choose to purchase a covered brand-name drug that has a generic equivalent, you will pay the Level 3 non-preferred brand-name copayment plus the difference in cost between the brand-name drug and the generic (ancillary charge), not to exceed the full retail cost of the covered drug. Certain covered drugs are excluded from this requirement. You pay only the applicable copayment for these covered brand-name drugs with generic equivalents: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol and Tegretol XR. One copayment covers up to a 90-day supply.

You have coverage for prescriptions of up to a 90-day supply at all participating, non-participating and mail service pharmacies. Prescriptions may be refilled for up to one year.

DRAFT - Co-Payment Amounts for Fee-for-Service, Managed Care & Family Health Plus

Service	Amount(s) for FFS	Amount for Managed Care	Amount(s) for FHPlus
Inpatient Hospital	$25 per stay upon discharge	No co-payment	$25 per stay upon discharge
Outpatient Hospital & Clinic	$3.00 per visit	No co-payment	$5.00 per visit
Non-emergency/Non-urgent ER	$3.00 per visit	No co-payment	$3.00 per visit
Prescription Drugs*			
Brand Name	$3.00	$3.00	$6.00
Generic	$1.00	$1.00	$3.00
Over-the-Counter Drugs (OTC) ** per medication	$0.50	No co-payment	$0.50
Enteral/Parental Formulae/Supplies	$1.00 per order/prescription	No co-payment	No co-payment
Covered Medical/Surgical Supplies***	$0.50 per order	No co-payment	$1.00 per supply
Laboratory	$0.50 per procedure code	No co-payment	$0.50 per procedure code
X-Ray ****	$1.00 per procedure	No co-payment	$1.00 per procedure
Dental Services	No co-payment	No co-payment	$5.00 per visit up to total of $25 per year
Physician Services	No co-payment	No co-payment	$5.00 per visit

* One co-payment for each new prescription and each new refill

** Covered OTC e.g., smoking cessation products, insulin

*** Covered medical supplies e.g., diabetic supplies such as syringes, lancets, test strips, enteral formula

**** Radiology services e.g., diagnostic x-rays, ultrasound, nuclear medicine & oncology services

Source: Medicaid Reference Guide (page 787-updated January 2009)

Co-Payments:

Medicaid and Family Health Plus recipients age 21 or older may be asked to pay part of the cost (co-payment) of some medical cate/items. There is a maximum of $200.00 per Medicaid recipient per year for all co-payments. The co-payment year begins on April 1 each year and ends on March 31 of the following year. Once the maximum has been reached, no co-payments will be required until the new benefit year begins. There is no maximum for Family Health Plus recipients.

Recipients exempt from co-payment include the following:

- Recipients under the age of 21;
- Pregnant women (This exemption continues for 2 months after the month in which the pregnancy ends.);
- Recipients institutuinalized in a medical facility who are required to spend all of their income, except for a personal needs allowance, on medical care. This includes all recipients in nurisng facilities and Intermediate Care Facilities for the Developmentally Disabled;
- Recipients enrolled in Medicaid Managed Care Plans (with the exception of pharmacy co-payments and OTC); and
- Residents of Adult Care Facilities licensed by DOH or OMH and OPWDD certified community residences and recipients enrolled in a Comprehensive Medicaid Care Managed Program, in an OPWDD Home and Community Based Services (HCBS) waiver program, or in a DOH HCBS waiver program for Personas with Traumatic Brain Injury.

Services exempt from co-payment include the following:

- Emergency Services;
- Family planning services and supplies (birth control pills or condom);
- Tuberculosis Directly Observed Therapy;
- Methadone Maintenance Treatment Programs, mental health health clinics services, mental retardation clinic services, and alcohol and substance abuse clinic services;
- Drugs to treat tuberculosis, and birth contol;
- Psychotropic drugs; and
- Prescription drugs for a resident of an Adult Care Facility licensed by the DOH.

NOTE:

Co-payments are not charged by private physicians and dentists enrolled in Medicaid or, for home health and personal care services. Private physicians and dentists in Family Health Plus may charge a co-payment.

Source: Medicaid Reference Guide (page 509-511-updated January 2001)

DRAFT - NEW YORK HMO COPAYMENT GUIDELINES

(UPDATED 10/06)

SERVICE	OLD MAXIMUM	NEW MAXIMUM
Inpatient Hospital	$500/cont. confinement	$1,000/cont. confinement
Primary Care	$25/visit	$30/visit
Specialty Care	$40/visit	$50/visit
Maternity	$25/visit 20% up to $200 for delivery	$30/visit 20% up to $300 for delivery
Ambulatory Surgery (Facility)	$75	$150
Surgery	20% up to $200	20% up to $300
Diagnostic Lab	20% up to $100/procedure $500 annual max	20% up to $100/procedure $500 annual max
Radiology	20% up to $100/procedure $500 annual max	20% up to $100/procedure $500 annual max
Preadmission testing	20% up to $100/procedure $500 annual max	20% up to $100/procedure $500 annual max
Home Health Care	$25/visit	$30 for 1st 52 visits, $0 after
Chemotherapy	$25/visit	$30 for 1st 52 visits, $0 after
Dialysis	$25/visit	$30 for 1st 52 visits, $0 after
Diabetic eq/supplies	$25	$30 for 1st 52, $0 after
Outpatient Chemical Dependence	$25	$30 for 1st 52 visits, $0 after
ER	$100 (waived if admitted)	$150 (waived if admitted)
Ambulance	$100	$100

Note, the copayments listed above, do not apply to group coverage offered by Article 43s and for-profit insurers.

DRAFT - 2011 COST SHARING UNDER FEDERAL EMPLOYEES HEALTH BENEFITS

Benefit	Specifics	BC/BS BASIC OPTION	BC/BS - STANDARD OPTION		
			PPO	Participating	Non-PPO
Doctors	Office Visits (PCP)	$25	$20	35% of plan allowance	35% + difference between bill and allowable amount
	Office Visits (Specialist)	$35	$30	35% of plan allowance	35% + difference between bill and allowable amount
	Inpatient Professional Services	No co-payment	15% of plan allowance	35% of plan allowance	35% + difference between bill and allowable amount
Lab, X-ray, & Other Diagnostics	Blood tests, EKGs, Lab tests, Neurological testing, pathology services, urinalysis	No co-payment	15% of plan allowance	35% of plan allowance	35% + difference between bill and allowable amount
	EEGs, Ultrasounds, X-rays OR diagnostic services billed by an independent lab	$25	15% of plan allowance	35% of plan allowance	35% + difference between bill and allowable amount
	Bone density tests, CT scans/MRIs/PET scans, diagnostic angiography, diagnostic genetic testing	$75	15% of plan allowance	35% of plan allowance	35% + difference between bill & allowable amount
Hospital	Surgical procedures*** and medical care	$150 per surgeon	15% of plan allowance	35% of plan allowance	35% + difference between bill & allowable amount
	Hospital Inpatient Room and Board/Hospital services and supplies	$150 per day up to $750 per admission	$250 per admission	$350 per admission plus 35% of the plan allowance	$350 per admission + 35% of the plan allowance + difference between bill & allowable amount
	Anesthesia	No co-payment	15% of plan allowance	35% of plan allowance	35% + difference between bill & allowable amount
	Outpatient hospital or ambulatory surgical center	$75 per day per facility	15% of plan allowance	35% of plan allowance	35% + difference between bill & allowable amount
Mental Health & Substance Abuse	Inpatient Hospital (pre-certification required)	$150 per day up to $750 per admission	$250 per admission	$350 per admission plus 35% of the plan allowance	$350 per admission + 35% of the plan allowance + difference between bill & allowable amount
	Inpatient Professional Visits	No co-payment	No co-payment	35% of plan allowance	35% + difference between bill & allowable amount
	Charges for facility-based intensive outpatient treatment/ diagnostic tests	No co-payment	15% of plan allowance	35% of plan allowance	35% + difference between bill & allowable amount
	Charges for intensive outpatient treatment in an office setting	$25	15% of plan allowance	35% of plan allowance	35% + difference between bill & allowable amount
	Outpatient hospital or other covered facility	$25	15% of plan allowance	35% of plan allowance	35% + difference between bill & allowable amount

DRAFT - 2011 COST SHARING UNDER FEDERAL EMPLOYEES HEALTH BENEFITS

Benefit	Specifics	BC/BS BASIC OPTION	BC/BS - STANDARD OPTION		
			PPO	Participating	Non-PPO
Prescription Drugs	Routine Immunizations & medicines to promote better health	No co-payment	No co-payment		Beneficiary pays all charges
	Tier 1 (generic) Drug	$10 for a 34-day supply $30 for a 90-day supply	20% of plan allowance		45% of plan allowance + difference between bill & allowable amount
	Tier 2 (preferred brand-name) Drug	$40 for a 34-day supply $120 for a 90-day supply	30% of plan allowance		45% of plan allowance + difference between bill & allowable amount
	Tier 3 (non-preferred brand-name) Drug	50% ($50 minimum) for a 34-day supply 50% ($150 minimum) for a 90-day supply	30% of plan allowance		45% of plan allowance + difference between bill & allowable amount
	Tier 4 (specialty) Drug	$40 for a 34-day supply $120 for a 90 day supply	30% of plan allowance		45% of plan allowance + difference between bill & allowable amount
Non-prescription drugs	Smoking cessation only	No co-payment	Nothing		Beneficiary pays all charges