

Rochester City School District 2010 vs 2009 Healthcare Plan Designs						
RCSD Benefit Plan Summary	2010 Plan Options		Current 2009 Plan Options			
Benefit Highlight	EPO Enhanced Plan	EPO Economy Plan	Select (Retirees)	Value (Active)	PC Community (Retirees)	PC Opportunity(Active)
Deductible	None	\$250/\$750	None	None	None	None
Coinsurance	None	Covered at 80%	None	None	None	None
Out of Pocket Max	None	\$750/\$2,250	None	None	None	None
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician	\$15 copay per visit	\$20 copay per visit	\$15 copay per visit	\$20 copay per visit	\$15 copay per visit	\$20 copay per visit
Specialist	\$15 copay per visit	\$40 copay per visit	\$15 copay per visit	\$20 copay per visit	\$15 copay per visit	\$20 copay per visit
Well Child Visits	Covered in Full	Covered in full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Routine Physical	Covered in Full	\$20 copay per visit	\$15 copay per visit	\$20 copay per visit	\$10 copay per visit	\$15 copay per visit
Sick Child Visits	\$0 to age 19	\$20 copay per visit	\$15 copay per visit	\$20 copay per visit	\$0 copay to age 4, \$10 copay to age 19 during regular office hours	\$0 copay to age 4, \$10 copay to age 19 during regular office hours
Allergies (Test and Injections)	\$15 copay per visit	\$20 copay per visit	\$15 copay per visit	\$20 copay per visit	\$15 copay per visit	\$20 copay per visit
Routine GYN Exam	\$10 copay per visit	\$20 copay per visit	\$15 copay per visit	\$20 copay per visit	Semi-annual visit covered at \$10 copay	Semi-annual visit covered at \$15 copay
Mammography	Covered in Full	Covered in Full	\$15 copay per visit	\$20 copay per visit	Covered in Full	Covered in Full
Chiropractic	\$15 copay when medically necessary	\$20 copay when medically necessary	\$15 copay per visit	\$20 copay per visit	\$15 copay per visit	\$20 copay per visit
Acupuncture	Covered at 50% up to 10 Visits	Covered at 50% up to 10 Visits	Covered at 50%, 10 visits	50%, 10 visits	Covered at 50%, 10 visits	Covered at 50%, 10 visits
Diagnostic Lab	Covered in full	\$20 copay per visit	Covered in Full	Covered in Full	Covered in Full	\$5 copay per visit
Diagnostic X-Ray	\$15 copay per visit	\$40 copay per visit	\$15 copay per visit	\$20 copay per visit	\$15 copay per visit	\$20 copay per visit
Maternity – Pre/Post	\$5 copay for first 10 visits; covered in full	\$5 copay for first 10 visits; covered in full	\$5 copay, first 10 visits	\$5 copay, first 10 visits	\$50 per pregnancy	\$50 copay per pregnancy
Maternity Hosp.	Covered in full	80% after deductible	Covered in Full	\$100 copay per admission	Covered in Full	\$100 copay per admission
Inpatient Hosp.	Covered in full	80% after deductible	Covered in Full	\$100 copay per admission	Covered in Full	\$100 copay per admission
Pre Admission Testing	Covered in full	Covered in full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Inpatient Surgery	Covered in full	20% or \$100 copay	Covered in Full	20% or \$100 copay	Covered in Full	\$100 copay, physician surgical fees 20% to \$100 copay
Anesthesia	Covered in full	80% after deductible	Covered in Full	Covered in Full	Covered in Full	\$100 copay, physician surgical fees 20% to \$100 copay
Outpatient Surgery	\$15 copay per visit	80% after deductible	\$15 copay per visit	\$50 copay Facility, \$20 Physician	\$15 copay per visit	\$50 copay Facility, \$20 copay Physician
Inpatient Mental Health	Covered in full for up to 30 days	80% after deductible up to 30 days	Covered in Full, up to 30 days	\$100 copay, up to 30 days	Covered in Full, up to 30 days	\$100 copay, up to 30 days
Outpatient Mental Health	\$15 copay up to 20 visits	\$40 copay up to 20 visits	\$15 copay, up to 20 visits	\$20 copay, up to 20 visits	\$15 copay, up to 20 visits	\$20 copay, up to 20 visits
Inpatient Substance Abuse	Covered in full up to 7 days of hospital care for detox	80% after deductible up to 7 days of hospital care for detox	Covered in Full, up to 7 days of hospital care for detox	\$100 copay, up to 7 days of hospital care for detox	Covered in Full, up to 7 days of hospital care for detox	\$100 copay, up to 7 days of hospital care for detox
Outpatient Substance Abuse	\$15 copay up to 60 visits	\$40 copay up to 60 visits	\$15 copay, up to 60 visits	\$20 copay, up to 60 visits	\$15 copay, up to 60 visits	\$20 copay, up to 60 visits
Chemotherapy/Radiation	Covered in Full	\$40 copay per visit	\$15 for IV/Injectible chemotherapy plus \$15 physician copay	\$20 copay for IV/Injectible chemotherapy plus \$20 physician copay	Covered in full for inpatient, Oral covered under Rx, IV/Injectible covered with \$15 specialist copayment, Physician administered injectiblechemotherapy \$15 plus any copayment for administering the drug, Radiation covered in full	Covered in full for inpatient, Oral covered under Rx, IV/Injectible covered with \$20 specialist copayment, Physician administered injectiblechemotherapy \$20 plus any copayment for administering the drug, Radiation covered in full
Rx	\$5/\$20/\$35	\$10/\$30/\$50	\$15/\$20/\$35	\$10/\$25/\$40	\$10/\$25/\$40	\$10/\$25/\$40
Rx Mail Order	1 copay for 90 day supply	2 copay for 90 day supply	3 copays for 90 day supply	3 copays for 90 day supply	\$25/\$62.50/\$100	\$25/\$62.50/\$100
Rx Maximum	None	None	None	None	None	None
Routine Vision	\$15 copay once every year	\$20 copay once every year	\$15 copay, one per year	\$20 copay, one per year	\$15 copay, one per year	\$20 copay, one per year
Eyewear	\$100 allowance annually	\$60 allowance annually	\$60 allowance per year	\$60 allowance per year	\$60 credit plus 20% discount allowance per year	\$60 credit plus 20% discount allowance per year
Hearing Exam	\$15 copay per visit	\$20 copay	\$15 copay per visit	\$20 copay per visit	\$15 copay per visit	\$20 copay per visit
Hearing Aids	Covered up to \$600 for up to 2 hearing aids every 3 years for children to age 19	Covered up to \$600 for up to 2 hearing aids every 3 years for children to age 19	Covered up to \$600 for two hearing aids every 3 years to age 19	Covered up to \$600 for two hearing aids every 3 years to age 19	Covered up to \$600 every three years to age 19	Covered up to \$600 every three years to age 19
Urgent Care/After Hours	\$25 copay per visit	\$25 copay per visit	\$25 copay per visit	\$25 copay per visit	\$25 copay per visit	\$25 copay per visit
Ambulance	\$15 copay per visit	\$50 copay per visit	\$25 copay per visit	\$50 copay per visit	\$15 copay per visit	\$50 copay per visit
Emergency Care	\$50 copay/waived if admitted	\$50 copay/waived if admitted	\$50 copay per visit	\$50 copay per visit	\$50 copay per visit	\$50 copay per visit
Home Care	Covered in full	\$20/day 40 visits per year	Covered in Full	Covered in Full	\$15 copay per day	\$20 copay per day
Private Duty Nursing	Covered in Full	\$40/day inpatient and at home	Covered in Full	Covered in Full	\$15 copay per day for inpatient, \$15 copay per day at home	\$20 copay per day for inpatient, \$20 copay per day at home
DME	Covered at 80% up to \$15,000 max. per member per calendar year	Covered at 50% up to \$5,000 max. per member per calendar year	Covered at 80% up to \$5,000 max per year	Covered at 50% up to \$5,000 max per year	Covered at 80% up to \$15,000 max per year	Covered at 50% up to \$5,000 max per year
Prosthetics	Internal Covered in Full/External covered at 80%	Internal Covered in Full/External covered at 50%	Covered at 80% up to \$15,000 max per year	Covered at 50% up to \$15,000 max per year	Covered at 80% up to \$15,000 max per year	Covered at 50% up to \$15,000 max per year
Physical, Speech, Occupational Therapy	\$15 copay up to 45 visits per year	\$40 copay up to 45 visits per year	\$15 copay, 30 visit max	\$20 copay, 30 visit max	\$15 copay, 45 visits	\$20 copay, 30 visits
Skilled Nursing Facility	Covered in full 120 days / 360 lifetime maximum	80% after deductible 120 days / 360 lifetime maximum	Covered in full up to 120 days per year, 360 day lifetime max.	\$100 copay per visit up to 120 days, 360 day lifetime max.	Covered in full up to 120 days	Covered up to 120 days after \$100 copay
Hospice	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Dependent Age	Qualified dependents 19. Full time students 25	Qualified dependents 19. Full time students 25	19/23	19/23	19/23	19/23
Domestic Partners	Covered - same sex only	Covered - same sex only	Covered - same sex only	Covered - same sex only	Covered - same sex only	Covered - same sex only
Out-of-Network	World Wide coverage	World Wide coverage	World Wide coverage	World Wide coverage	World Wide coverage	World Wide coverage

This plan design contains only a general description of the coverage and does not constitute a policy contract. For complete information including exclusions, limitations and conditions, refer to the policy document. Neither the carrier nor Brown & Brown will be held responsible for typographical or clerical errors.