



ARCC Blue Shield Rates effective January 1, 2010

Benefits	Blue Shield HMO 206 Plus (Only In-Network benefits are shown below)	Blue Shield POS 7100 (Only In-Network benefits are shown below)	Blue Shield Medicare 799 PPO (Only In-Network benefits are shown below)
Deductible	N/A	\$1,500 Single/\$3,000 True Family	N/A
Coinsurance	N/A	N/A	20% where applies
Coinsurance Out-of-Pocket Max	N/A	\$5,000 Single/\$10,000 Family	\$3,000
Annual Benefit Maximum	Unlimited	Unlimited	Unlimited
Medical Home/Office			
Office/ Home Visits PCP/Specialist	\$10/\$40 or \$20/\$30 or \$25/\$25	\$0 copay after deductible	\$20
Well Child Care (Including immunizations)	Covered in Full	Covered in Full	N/A
Maternity Care	Pre & Post Natal Care covered in full after copay for initial visit	Pre & Post Natal Care \$0 copay after deductible; Inpatient maternity stay covered in full after deductible	N/A
Annual GYN Exam (Self Referred)	PCP Copay	Covered in Full	\$0
Chiropractic Care	\$10	\$0 copay after deductible	\$20
Hospital Inpatient			
Hospital	\$500	\$0 copay after deductible	\$250
Routine Nursery	Included in Inpatient Benefit	Included in Inpatient Benefit	N/A
Surgery	Included in Inpatient Benefit	Included in Inpatient Benefit	Included in Inpatient Benefit
Surgical Assistant	Included in Inpatient Benefit	Included in Inpatient Benefit	Included in Inpatient Benefit
Second Surgical Opinion	Included in Inpatient Benefit	Included in Inpatient Benefit	\$20
Anesthesia	Included in Inpatient Benefit	Included in Inpatient Benefit	Included in Inpatient Benefit
Mental & Nervous	30 days; \$500 copay	30 days aggregate with out- of-network; \$0 copay after deductible	190 day lifetime limit; \$250
Alcohol/Substance Abuse	30 days detox, \$500 copay; No inpatient rehab	30 days inpatient substance abuse, 7 days detox, No inpatient rehab; \$0 copay after deductible	\$250
Outpatient			
Laboratory Testing	Covered in Full	\$0 copay after deductible	\$0
Diagnostic Xrays	Covered in Full	\$0 copay after deductible	\$20
MRI's	Covered in Full	\$0 copay after deductible	\$0 copay in-network; \$25 copay out-of-network
Ambulatory surgery	\$75	\$0 copay after deductible	\$35
Pre Surgery Testing	Covered in Full	\$0 copay after deductible	\$0 copay in-network; \$25 copay out-of-network
Chemo & radiation therapy	Specialist Copay	\$0 copay after deductible	\$20

Kidney dialysis	Specialist Copay	\$0 copay after deductible	\$0 copay in-network; \$25 copay out-of-network
Mental Health	20 days; Specialist copay/visit	20 days; \$0 copay after deductible	20% Coinsurance
Alcohol & Substance Abuse	60 visits; Specialist copay/visit	60 visits aggregate with OON; \$0 copay after deductible	20% Coinsurance
Physical Therapy	20 visits aggregate; specialist copay	\$0 copay after deductible; 20 visits aggregate	\$20
Emergency Room	\$100	\$0 copay after deductible	\$50
Home Health Care	Covered in Full	40 visit limit; \$0 copay after deductible	\$0
Hospice	Covered in Full	\$0 copay after deductible	\$0
Skilled Nursing Facility	Non-Custodial; \$500	Non-Custodial; \$0 copay after deductible	100 days per benefit period; \$250
Additional Benefits			
Mammography & Diagnostic Screening	Covered in Full	Covered in Full	\$0
Durable Medical Equipment, Prosthetics, Medical Supplies	50% copay; \$1,000 annual max	\$0 copay after deductible; \$1,000 annual max	20% Coinsurance
Ambulance	\$100	\$0 copay after deductible	\$50
Prescription Drugs	\$15/\$50/50% with mandatory mail order for maintenance drugs	\$15/\$50/50% with mandatory mail order for maintenance drugs	\$7/\$30/\$50/\$50
Vision care	Annual exam; specialist copay	Exam every other year; \$0 copay after deductible	One routine exam every 24 months; \$25 copay; \$75 frames & lenses; \$75 contact lenses
Annual Dental Exam & Cleaning	Annual exam and cleaning with specialist copay	Not Covered	\$75 allowance for cleaning and other services
Dependent children/ dependent students	Age 19/25	Age 19/25	N/A
Out of Area College	Guest membership Available	Guest membership Available	N/A
Out of Area Coverage	30% Coinsurance after \$1,000 deductible	30% coinsurance after combined in and out of network deductible	Yes
Groups of 2-49 Rates	Quarterly	Quarterly	Quarterly
Individual	\$1,524.21	\$902.43	
Two-Person	\$3,124.65	\$1,849.95	N/A
Family	\$4,161.15	\$2,537.64	N/A
Sole Proprietor Rates			
Individual	\$1,662.18	\$902.43	N/A
Two-Person	\$3,407.55	\$1,849.95	N/A
Family	\$4,537.83	\$2,537.64	N/A

This is a benefit summary only, and is subject to the terms, conditions, limitations, and exclusions set forth in the contract. Please check with carrier for policies regarding prior authorization.

*Please be sure to verify if your Doctor participates in the plan you are choosing. Also ask for a drug formulary if you are currently taking medications. *NYS-45 ATT, K-1 or 1120 MUST BE SUBMITTED, plus DBA where required. Quarterly rates shown do not include standard assessed \$20 administrative fee.*