### Plan Features**

<table>
<thead>
<tr>
<th>Deductible (per calendar year)</th>
<th>HMO Blue-CNY</th>
<th>MVP-CNY (HMO)</th>
<th>Empire Plan*** Participating Providers</th>
<th>Empire Plan*** Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>$1250 Per Enrollee</td>
</tr>
<tr>
<td>Out-of-Pocket Max. per calendar year (does not include deductible)</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>$1250 Per Spouse/Domestic Partner and</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>None</td>
<td></td>
<td>$1250 all Dep. Children Combined</td>
</tr>
<tr>
<td></td>
<td>Unlimited</td>
<td>Not applicable</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td></td>
<td>$6350 Individual</td>
<td>$6,350 Individual</td>
<td>***Medical $5,650 Individual</td>
<td>$3750 Per Enrollee,</td>
</tr>
<tr>
<td></td>
<td>$12,700 Family</td>
<td>$12,700 Family</td>
<td>Medical $11,300 Family</td>
<td>$3750 Per Spouse/Domestic Partner and</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Rx $3,050 Individual</td>
<td>$3750 all Dep. Children Combined</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rx $6,100 Family</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive, Routine, and Specialty Care

#### Routine Physical Exams
- No copay: 100% Covered
- No cost ($25 copay may apply; some tests have age limitations)
- Not covered: routine

#### Hearing Exams
- $40, once every 12 months for routine
- $25 (specialist)
- $25 Copay
- Included in hearing aid coverage

#### Hearing Aids
- No cost: up to 2 hearing aids every 3 calendar years for children up to age 19
- Not covered: routine
- No current in-network providers
- Up to $1500 per hearing aid per ear (every 4 years)

#### Eye Exams
- Routine: Not Covered Diagnostic
- $40 specialist copay
- Routine exam $25 copay every 2 years/Diagnostic specialist $25 copay
- Not covered: routine

#### Immunizations
- No cost: 100% Covered
- No cost for select preventative immunizations. (Vaccines received by participating pharmacies in CVS network are covered for patients age 18 or older)
- Not covered

#### Allergy Treatment
- Testing and injections-$25 (PCP), $40 (specialist)/visit
- 100% Covered
- $25 Copay for office visit
- injections: No cost
- 80% of R&C after deductible

#### Physician Visits/Diagnostic
- $25 (PCP), $40 (specialist)
- $25 (for children to age 26)/office, $25 specialist
- $25 Copay
- 80% of R&C after deductible

#### Telehealth
- 100% Covered
- $25 (PCP); (100% using GIA app)
- 80% of R&C after deductible

### Pediatric Care (To Age 19)

#### Well Child Visits
- No Cost
- 100% Covered
- No copay:
- Not covered: routine
- 80% of R&C after deductible

#### Immunizations
- No Cost
- 100% Covered
- No copay:
- Not covered: influenza vaccine
- 80% of R&C after deductible

#### Sick Visits
- $25 (PCP), $40 (specialist)
- $0; applies to all dependents up to age 26
- $25 Copay
- 80% of R&C after deductible

#### New Born Allowance
- No Cost
- No copay:
- Not covered: routine
- Unlimited: Not subject to deductible or coinsurance

### Women's Health Care/OB-GYN

#### Pap Tests*
- No cost (routine)
- 100% Covered
- No cost (office)
- $40 (hospital)
- 80% of R&C after deductible

#### Mammograms*
- No cost (routine)
- 100% Covered
- No cost (office)
- $40 (hospital)
- 80% of R&C after deductible

#### Bone Density Tests
- $40
- 100% Covered
- No cost (office)
- $40 (hospital)
- 80% of R&C after deductible

#### Gynecology Visits*
- No cost (routine)
- 100% Covered
- No cost:
- 80% of R&C after deductible

#### Pre- and Post-Natal Visits
- No cost:
- $25 for initial visit only
- No cost:
- 80% of R&C after deductible

#### Hospital Delivery
- Physician: lesser of $200 copay or 20% coinsurance
- 100% Covered
- No cost:
- 90% Charges reimbursed

#### Nursery Charges
- No cost:
- 100% Covered
- No cost:
- 90% Charges reimbursed

#### Infertility Services
- $25 (PCP), $40 (specialist)
- $25 (PCP), $25 (specialist)
- $25 copay or no cost if received at a center of excellence (precert. req.);
- $50,000 Lifetime max
- 80% of R&C after deductible:
- $50,000 Lifetime max

#### Contraceptive Drugs & Devices
- No cost for certain drugs/devices, otherwise applicable Rx copay applies
- 100% Covered
- No cost:
- Generic and drugs without a generic equivalent
- 80% of R&C after deductible

### Diagnostic & Therapeutic Services/Outpatient

#### X-Ray
- $40
- $25
- $25 Copay (Dr. office or participating lab);
- $50 Copay (hospital)
- 80% of R&C after deductible (Dr. office or nonpar lab); employee pays 10% of charges or $75 whichever is greater (hospital)

#### Lab Tests
- No cost
- No copay
- $25 Copay (Dr. office or participating lab);
- $50 Copay (hospital)
- 80% of R&C after deductible (Dr. office or nonpar lab); employee pays 10% of charges or $75 whichever is greater (hospital)

#### Pathology
- No cost
- No copay
- $25 Copay (Dr. office or participating lab);
- $50 Copay (hospital)
- 80% of R&C after deductible (Dr. office or nonpar lab); employee pays 10% of charges or $75 whichever is greater (hospital)

#### EKG/EEG
- $40
- $25
- $25 Copay (Dr. office or participating lab);
- $50 Copay (hospital)
- 80% of R&C after deductible (Dr. office or nonpar lab); employee pays 10% of charges or $75 whichever is greater (hospital)

#### Radiation/Chemotherapy
- $25
- $25
- $25 Copay (Dr. office or participating lab);
- $50 Copay (hospital)
- 80% of R&C after deductible (Dr. office or nonpar lab); employee pays 10% of charges or $75 whichever is greater (hospital)
<table>
<thead>
<tr>
<th>Plan Features**</th>
<th>HMO Blue-CNY</th>
<th>MVP-CYN (HMO)</th>
<th>Empire Plan Participating Providers</th>
<th>Empire Plan Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Care/Inpatient</td>
<td></td>
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<tr>
<td>Semi-Private Room</td>
<td>No cost</td>
<td>100% Covered</td>
<td>No cost</td>
<td>90% of charges reimbursed</td>
</tr>
<tr>
<td>Private Room if Medically Necessary</td>
<td>No cost</td>
<td>100% Covered</td>
<td>No cost: Isolation</td>
<td>90% of charges reimbursed</td>
</tr>
<tr>
<td>Physician Services</td>
<td>Physician surgery: Lesser of $200 copay or 20% coinsurance</td>
<td>100% Covered</td>
<td>No cost</td>
<td>80% of R&amp;C after deductible</td>
</tr>
<tr>
<td>Radiation/Chemotherapy</td>
<td>$25</td>
<td>$25</td>
<td>No cost</td>
<td>90% of charges reimbursed</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Anesthesiology, Pathology, Radiology</td>
<td>No cost</td>
<td>100% Covered</td>
<td>100% Coverage even through nonparticipating provider</td>
<td>100% Coverage</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>No copayment at designated center of excel (auth. req.)</td>
<td>100% Covered</td>
<td>No copayment at designated centers of excellence (precertification required); Physician--$25/Visit</td>
<td>80% of R&amp;C after deductible</td>
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<tr>
<td>Hospital Alternatives</td>
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<tr>
<td>Skilled Nursing Facility</td>
<td>No cost: Max 45 days</td>
<td>No copay: Max 45 days</td>
<td>No cost: 120 day max (precertification required)</td>
<td>Not covered</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>No cost: Max 40 days</td>
<td>$25/visit</td>
<td>HCAP no cost (network)</td>
<td>50% Network allowance after deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>No cost: Max 210 days</td>
<td>No copay: Max 210 days</td>
<td>No cost: At least 210 days</td>
<td>Not covered</td>
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<tr>
<td>Worldwide Emergency Care</td>
<td></td>
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<tr>
<td>At Home “After Hours” (ER)</td>
<td>$100-waived if admitted</td>
<td>$75/visit</td>
<td>$100 Copay: Waived if admitted</td>
<td>80% of R&amp;C after deductible</td>
</tr>
<tr>
<td>When You Travel (ER)</td>
<td>$100-waived if admitted</td>
<td>$75/visit</td>
<td>$100 Copay: Waived if admitted</td>
<td>80% of R&amp;C after deductible</td>
</tr>
<tr>
<td>Walk-in Center</td>
<td>$35</td>
<td>$15/visit</td>
<td>$30 Copay: $100 if billed as ER</td>
<td>80% of R&amp;C after deductible</td>
</tr>
<tr>
<td>Ambulance - Medically Necessary</td>
<td>$100 (includes air ambulance)</td>
<td>$50 per trip</td>
<td>$70 Copay</td>
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<tr>
<td>Mental Health Services</td>
<td></td>
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<tr>
<td>Inpatient</td>
<td>No cost: No max # of days</td>
<td>No copay: No max # of days</td>
<td>Beacon Health Network-No Cost-No Max Days</td>
<td>90% After deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$25 Copay: No max # of days</td>
<td>$25 copay: No max # of days</td>
<td>Beacon Health Network - $25 Copay-No Max Visits</td>
<td>80% After deductible</td>
</tr>
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<tr>
<td>Alcohol/Drug Abuse Services</td>
<td></td>
<td></td>
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<tr>
<td>Detoxification</td>
<td>No cost, unlimited</td>
<td>No copay: No max # of days</td>
<td>Beacon Health Network-No cost</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Inpatient Rehab - Alcohol</td>
<td>No cost: No max # of days</td>
<td>No copay: No max # of days</td>
<td>Beacon Health Network-No cost</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Inpatient Rehab - Drug</td>
<td>No cost: No max # of days</td>
<td>No copay: No max # of days</td>
<td>Beacon Health Network-No cost</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Outpatient Rehab</td>
<td>$25—No max # of days</td>
<td>$25 Copay: No max # of days</td>
<td>Beacon Health Network - $25 copay-Max 20 visit Substance Use Family Therapy</td>
<td>80% after. Max 20 visit Substance Use Family Therapy</td>
</tr>
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<tr>
<td>Rehabilitative Care</td>
<td></td>
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</tr>
<tr>
<td>Physical Therapy: Outpatient</td>
<td>$40 copay: Max 30 visits (combined physical, speech &amp; occupational)</td>
<td>$25 copay: no maximum</td>
<td>At hospital–after hospitalization: $25 copay; At physical therapy office $25 copay; under MPN program</td>
<td>$250 Deductible: 50% network allowance</td>
</tr>
<tr>
<td>Chiropractic Therapy</td>
<td>$40</td>
<td>$25</td>
<td>$25 copay; no max</td>
<td>80% of R&amp;C after deductible</td>
</tr>
<tr>
<td>Speech Therapy: Short Term to Restore Normal Speech (with Significant Clinical Improvement)</td>
<td>$40 copay: Max 30 visits (combined physical, speech &amp; occupational)</td>
<td>See physical therapy</td>
<td>HCAP: No cost Participating provider: $25 Copay</td>
<td>80% of R&amp;C after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment &amp; Supplies</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
<td>HCAP: No cost</td>
<td>50% of network reimbursement after deductible</td>
</tr>
<tr>
<td>Prosthetics and Orthotics</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
<td>No cost</td>
<td>80% of R&amp;C after deductible</td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Prescription Drugs/Outpatient*</td>
<td></td>
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</tr>
<tr>
<td>Retail – up to a 30 Day Supply</td>
<td>$10/$30/$50</td>
<td>$0 Generic/$30/$50</td>
<td>$5/$30/$60</td>
<td>Non-par. Pharmacy: AWP less appropriate tier copay</td>
</tr>
<tr>
<td>generic (preferred/nonpreferred)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Retail – up to a 90 Day Supply</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>$10/$60/$120</td>
<td>Non-par. Pharmacy: AWP less appropriate tier copay</td>
</tr>
<tr>
<td>generic (preferred/nonpreferred)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mail Order – up to a 90 Day Supply</td>
<td>$20/Generic $60/Preferred brand name $100/Non-preferred brand name: Up to 90 day supply</td>
<td>$5/Gener $75/Preferred brand name $125/Non-preferred brand name</td>
<td>$5/Generic $55/Preferred brand name $110/Non-preferred brand name</td>
<td>Non-participating pharmacy: Average wholesale price less appropriate tier copay</td>
</tr>
<tr>
<td>Diabetic Supplies</td>
<td>$25 per 30 day supply (incl. insulin and oral agents)</td>
<td>$15 per 31 day supply per boxed item (incl. insulin and oral agents)</td>
<td>Equipment: No cost under HCAP program; Insulin covered under Rx program</td>
<td>Insulin: AWP less appropriate tier copay under Rx; Equip.: 50% of network reimb. after deductible</td>
</tr>
</tbody>
</table>

* R&C = Reasonable and Customary; 
** Age and maximum limits in this column pertain to HMO Blue-CNY coverage only. 
*** Empire plan out of pocket max does not cross apply; 

Updated 12/02/2021