Effective June 1, 2019

Contract College Health Plan Comparison Chart

While every attempt has been made to ensure the accuracy of this summary, in the event of any discrepancy, the Summary Plan Description and Plan Document will prevail.

Plan Features**	HMO Blue-CNY	MVP-CNY (HMO)	Empire Plan*** Participating Providers	Empire Plan*** Non-Participating Providers
Deductible (per calendar year)	None	None	None	$1250 Per Enrollee $1250 Per Spouse/Domestic Partner and $1250 all Dep. Children Combined
Lifetime Maximum	Unlimited	Not applicable	Unlimited	Unlimited
Out-of-Pocket Max. per calendar year (does not include deductible)	$6350 Individual $12,700 Family	$6,350 Individual $12,700 Family	***Medical $5,150 Individual Medical $10,300 Family Rx $2,750 Individual Rx $5,500 Family	$3750 Per Enrollee, $3750 Per Spouse/Domestic Partner and $3750 all Dep. Children Combined
Preventive, Routine, and Specialty Care				
Routine Physical Exams	No copay	100% Covered	No cost ($25 copay may apply; some tests have age limitations)	Employee or spouse/domestic partner: No coverage under age 50; over 50 covered at 100%; not subject to ded. or coinsurance
Hearing Exams	$40, once every 12 months for routine	$40 (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	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 $40 copay	Not covered: routine	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 ($10 for children) /office, $40 (specialist)	$25 Copay	80% of R&C after deductible
Pediatric Care (To Age 19)				
Well Child Visits	No Cost	100% Covered	No cost	80% of R&C after deductible
Immunizations	No Cost	100% Covered	No cost (Incl. influenza vaccine)	80% of R&C after deductible
Sick Visits	$25 (PCP), $40 (specialist)	$10; applies to all dependents up to age 26	$25 Copay	80% of R&C after deductible
New Born Allowance	No Cost	No cost	No cost	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	$25	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), $40 (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		
Pathology	No cost	No copay		
EKG/EEG	$40	$25		
Radiation/Chemotherapy	$25	$40	No cost	80% of R&C after deductible (Dr. office or nonpar lab); employee pays 10% of charges or $75 whichever is greater (hospital)

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

* 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 4/29/2019