

## Health Plan Comparison Chart: Security Officers

<b>Name of Plan</b>	<b>Empire BCBS Deluxe PPO</b>	<b>MVP Health Plan</b>
<i>Type of Plan</i>	Preferred Provider Organization (PPO)	Health Maintenance Organization (HMO)
<i>Features</i>	Network plus freedom of choice	Network only
<i>Primary Care Provider Required</i>	NO	YES
<i>Deductible (Individual/Family)</i>	In Network: \$0 for medical services; \$200 for brand name RX Out of Network: \$500/\$1,250 for medical services	Not Applicable
<i>Coinsurance: the % you pay after deductible</i>	In Network: None Out of Network: 20%	Not Applicable
<i>Maximum Out of Pocket (Individual/Family)</i>	In Network: \$5,080 / \$12,700 (All In –Network copays) Out of Network: \$1,000/\$2,000	\$5,800 / \$12,700 ( <del>\$5,080</del> ) / \$12,700 (All In –Network copays)
<i>Emergency Room</i>	\$75-waived if admitted in 24 hrs	\$50 waived if hospitalized
<i>Home/Office Visit</i>	In Network: \$20 copay Out of Network: Deductible & Coinsurance	\$15 copay
<i>Lab &amp; Testing</i>	In Network: \$0 Out of Network: Deductible & Coinsurance	\$15 copay
<i>Annual Physical</i>	In Network: \$0 copay. Out of Network: Not Covered	\$15 copay
<i>Preventative GYN screen</i>	In Network: \$0 copay. Out of Network: Deductible & Coinsurance	\$15 copay
<i>Inpatient Hospitalization</i>	In Network: \$250 copay. Out of Network: Deductible & Coinsurance	No charge
<i>Vision Care:</i>		
<i>Eye Exams</i>	\$10 copay; one visit every 2 years	\$15 copay ; one visit every 2 years
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<i>Glasses / Contact Lenses</i>	In Network: \$135 allowance per year, plus 15% of additional costs. Out of Network: \$25-\$55 allowance	Not covered Not covered
<i>Prescriptions</i>	\$10 copay for Generic \$25 or \$50 for Brand after a \$200 deductible	\$5 copay for Generic \$20 copay for Formulary Brand \$40 for Non-formulary Brand
<i>Children's Preventive Dental Care</i>	Not covered	2 visits/year for children under 19
<i>Mental Health Care:</i>		
<i>Inpatient Hospital</i>	Inpatient : In-network: \$250 copay. Out-of-network: Deductible & Coinsurance	\$0 inpatient
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<i>Inpatient Physician</i>	In-network: \$0 Out-of-network: Deductible & Coinsurance	\$15 copay
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<i>Outpatient Physician</i>	In-network: \$20 copay/visit Out of network: Deductible & Coinsurance	Outpatient-: \$15 copay
<i>Alcohol/Substance Abuse</i>		
<i>Inpatient</i>	\$0 ; inpatient drug/alcohol rehab limited to 30 days/year	\$0 Detoxification
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<i>Outpatient</i>	\$20 copay	\$15 copay
<i>Physical Therapy</i>	\$20 per visit up to 90 visits per year (Covered In-network only)	\$15 per visit; maximum 60 day period per injury