

Health Plan Comparison Chart: Faculty and Administrators

Name of Plan	Empire BCBS Deluxe PPO	MVP Health Plan
<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 Out of Network: \$500/\$1,250	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: None Out of Network (Deductible plus coinsurance): \$1,500/\$3,750	None
<i>Emergency Room</i>	\$50-waived if admitted in 24 hrs	\$50 waived if hospitalized
<i>Home/Office Visit</i>	In Network: \$15 copay Out of Network: Deductible & Coinsurance	\$15 copay
<i>Lab & Testing</i>	In Network: \$0 Out of Network: Deductible & Coinsurance	\$15 copay
<i>Annual Physical</i>	In Network: \$15 copay. Out of Network: Not Covered	\$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>	\$5 copay; one visit every 2 years	\$15 copay ; one visit every 2 years
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<i>Glasses</i>	Glasses \$10 - \$80 copay depending on lens and frame type	Not covered
<i>Contact Lenses</i>	Contact lenses \$25	Not covered
<i>Prescriptions</i>	\$10 copay for Generic \$20 for Formulary Brand \$40 for Non-Formulary Brand	\$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 : Up to 30 days/yr In-network: \$0 Out-of-network: Deductible & Coinsurance	\$0 inpatient-30 day maximum
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<i>Inpatient Physician</i>	Limit: 30 visits/yr. In-network: \$0 Out-of-network: Deductible & Coinsurance	50% or \$45 copay to 20 visit maximum
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<i>Outpatient Physician</i>	Limit: 60 visits In-network: \$25 copay/visit Out of network: Deductible & Coinsurance	Outpatient-20 visit max: \$15 copay/1st visit, \$25 copay/visits 2-5, 50% or \$45 copay visits 6-20
<i>Alcohol/Substance Abuse</i>		
<i>Inpatient</i>	\$0 up to 30 days/year	\$0 Detoxification
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<i>Outpatient</i>	\$0 up to 60 visits/year	\$15 up to 60 visits/year
<i>Physical Therapy</i>	\$12 per visit up to 90 visits per year (Covered In-network only)	\$15 per visit; maximum 60 day period per injury