

**HEALTH PLAN COMPARISON CHART: STAFF AND SUPERVISORS**

<b>Name of Plan</b>	<b>Empire BCBS Deluxe PPO</b>	<b>MVP Health Plan</b>	<b>MVP Choices*</b>	<b>BCBS Tradition Plus Indemnity *</b>
<i>Type of Plan</i>	Preferred Provider Organization (PPO)	Health Maintenance Organization (HMO)	Point of Service (POS)	Indemnity Plan
<i>Features</i>	Network plus freedom of choice	Network only	Network plus freedom of choice	Freedom of choice only
<i>Primary Care Provider Required</i>	NO	YES	YES	NO
<i>Deductible (Individual/Family)</i>	In Network: \$0 Out of Network: \$200/\$500	Not Applicable	In Network: \$0 Out of Network: \$250/\$500	\$150 / \$300
<i>Coinsurance: the % you pay after deductible</i>	In Network: None Out of Network: 20%	Not Applicable	In Network: None Out of Network: 30%	20% to \$500 (individual) / \$1,000 (family)
<i>Maximum Out of Pocket (Individual/Family)</i>	In Network: None Out of Network: \$1,000/\$2,000	None	In Network: None Out of Network: \$2,500/\$5,000	\$650 / \$1,300
<i>Emergency Room</i>	\$35-waived if admitted in 24 hrs	\$50 waived if hospitalized	\$50 waived if hospitalized	\$0 if for serious injury/ serious medical condition
<i>Home/Office Visit</i>	In Network: \$12 copay Out of Network: Deductible & Coinsurance	\$15 copay	In Network: \$15 copay Out of Network: Deductible and Coinsurance	Deductible & Coinsurance
<i>Lab &amp; Testing</i>	In Network: \$0 Out of Network: Deductible & Coinsurance	\$15 copay	In Network: \$0 Out of Network: Deductible and Coinsurance	Deductible & Coinsurance, with annual <i>combined</i> 30 visit limit for outpatient surgery, ambulatory surgery, mammograms and blood work
<i>Annual Physical</i>	\$12 copay	\$15 copay	\$15 copay (In network Only)	Not covered
<i>Vision: Exam every 2 yrs</i>	\$5 copay	\$15 copay	\$15 copay (In network only)	Not covered
<i>Vision: Eyewear</i>	Glasses \$10 - \$80 copay Contact lenses \$25 copay	Not covered	Not covered	Not covered
<i>Prescriptions</i>	\$5 copay for Generic \$15 for Formulary Brand \$25 for Non-Formulary Brand	\$5 copay for Generic \$20 for Formulary Brand \$40 for Non-Formulary Brand	\$5 copay for Generic \$20 for Formulary Brand \$40 for Non-Formulary Brand	\$5 copay for Generic; Ancillary charge \$ difference between generic and brand
<i>Children's Preventive Dental Care</i>	Not covered	2 visits/yr for children under 19	2 visits/yr for children under 19	Not covered
<i>Mental Health: Inpatient</i>	Inpatient : Up to 30 days/yr In-network: \$0 Out-of-network: Deductible & Coinsurance	\$0 inpatient-30 day maximum	For all mental health services: In Network: same as HMO Out-of-network: Deductible & Coinsurance	\$0 up to 30 inpatient visits/year
<i>Inpatient Physician</i>	Limit: 30 visits/yr. In-network: \$0 Out-of-network: Deductible & Coinsurance	50% or \$45 copay to 20 visit maximum		Deductible & Coinsurance up to 30 visits/yr.
<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		Deductible & Coinsurance
<i>Alcohol/Substance Abuse Inpatient</i>	\$0 up to 30 days/year	\$0 Detoxification	Standard HMO Benefit	Up to 30 days/year: deductible and coinsurance
<i>Outpatient</i>	\$0 up to 60 visits/year	\$15 up to 60 visits/year	Deductible and coinsurance	Up to 60 visits/year: deductible and coinsurance

\* MVP Choices and Empire Tradition Plus are not available to staff/supervisors hired after July 1, 2004.