

Health Plan Comparison Chart: Faculty and Administrators

Empire Blue Cross Plan	Preferred Provider Organization (PPO)	Exclusive Provider Organization (EPO)
<i>Features</i>	Network plus freedom of choice	Network only
<i>Primary Care Provider Required</i>	NO	
<i>Dependent Children Covered Until...</i>	December 31 of the year the child turns 23 (whether or not s/he is a student)	
<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 inpatient within 24 hrs	
<i>Home/Office Visit</i>	In Network: \$15 copay Out of Network: Deductible & Coinsurance	\$20 copay
<i>Lab & Testing</i>	In Network: \$0 Out of Network: Deductible & Coinsurance	\$20 copay
<i>Annual Physical</i>	In Network: \$0 copay. Out of Network: Not Covered	\$0 copay
<i>Well-Woman Care (Annual gyn/pap, mammogram and bone density at certain age thresholds)</i>	In Network: \$0 Out of Network: Deductible & Coinsurance	\$0 copay
<i>Well Child Care (To age 19, including necessary immunizations)</i>	In Network: \$0 copay Out of Network: Deductible & Coinsurance	\$ 0 copay
<i>Inpatient Hospitalization</i>	In Network: \$250 copay. Out of Network: Deductible & Coinsurance	\$250 copay
<i>Vision Care: Exam</i>	In Network: \$10 copay; one visit every 2 years Out of network: \$40 allowance	\$10 copay; one visit every 2 years
..... <i>Glasses/ Contact Lenses</i>	In Network: \$130 allowance then 15% off balance of cost Out of Network: \$25 - \$55 allowance \$130 allowance then 15% off balance of cost
<i>Prescriptions</i>	\$10 copay for Generic \$20 for Formulary Brand \$40 for Non-Formulary Brand	\$10 copay for Generic \$25 copay for Formulary Brand \$50 for Non-formulary Brand
<i>Mental Health Care / Alcohol or Substance Abuse Treatment: Hospital And Inpatient Physician Outpatient Physician</i>	In-network: \$250 copay. Out-of-network: Deductible & Coinsurance (Inpatient Alcohol/Substance rehabilitation limited to 30 days/year) In-network: \$15 copay/visit Out of network: Deductible & Coinsurance (no Out of pocket cap)	\$250 copay \$20 copay/visit
<i>Physical Therapy</i>	\$15 per visit up to 90 visits per year (Covered In-network only)	\$20 per visit up to 60 visits per year
<i>Chiropractor</i>	In Network: \$15 copay Out of Network: Deductible & Coinsurance	\$20 copay