

Health Plan Comparison Chart: Faculty and Administrators

Empire Blue Cross Plan	Preferred Provider Organization (PPO)	Exclusive Provider Organization (EPO)	High Deductible Health Plan (HDHP)
<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 26 (whether or not s/he is a student)		
<i>Deductible (Individual/Family)</i>	In Network: \$0 for medical services; \$200 for brand RX Out of Network: \$500/\$1,250 for medical services; \$200 for brand RX	\$200 for brand RX only	\$2,500 / \$5,000
<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 (Deductible plus coinsurance): \$1,500/\$3,750	\$5,080 / \$12,700 (All In – Network copays)	\$2,500 / \$5,000
<i>Emergency Room</i>	\$75-waived if admitted inpatient within 24 hrs		100% after deductible
<i>Home/Office Visit</i>	In Network: \$20 copay Out of Network: Deductible & Coinsurance	\$25 copay	100% after deductible
<i>Lab & Testing</i>	In Network: \$0 Out of Network: Deductible & Coinsurance	\$0 copay	100% after deductible
<i>Annual Physical</i>	In Network: \$0 copay. Out of Network: Not Covered	\$0 copay	\$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	\$0 copay
<i>Well Child Care (To age 19, including necessary immunizations)</i>	In Network: \$0 copay Out of Network: Deductible & Coinsurance	\$0 copay	\$0 copay
<i>Inpatient Hospitalization</i>	In Network: \$250 copay. Out of Network: Deductible & Coinsurance	\$250 copay	100% after deductible
<i>Vision Care: Exam</i> <i>Glasses / Contact Lenses</i>	In Network: \$10 copay; one visit every 2 years. Out of network: \$40 allowance In Network: \$130 allowance then 15% off balance of cost. Out of Network: \$25 - \$55 allowance		
<i>Prescriptions</i>	\$10 copay for Generic \$25 / \$50 for Brand after \$200 deductible	\$10 copay for Generic	100% after deductible
<i>Mail-Order Prescriptions</i>	\$20 copay for 3- month supply of generic RX \$50 / \$100 for 3-month supply of brand-name RX; no deductible	\$20 copay for 3- month supply of generic RX	100% after deductible
<i>Mental Health Care / Alcohol or Substance Abuse Treatment: Hospital And Inpatient Physician</i> <i>Outpatient Physician</i>	In-network: \$250 copay. Out-of-network: Deductible & Coinsurance (Inpatient Alcohol/Substance rehabilitation limited to 30 days/year) In-network: \$20 copay/visit Out of network: Deductible & Coinsurance (no Out of pocket cap)	\$250 copay \$25 copay/visit	100% after deductible
<i>Physical Therapy</i>	\$20 per visit up to 90 visits per year (Covered In-network only)	\$25 per visit up to 60 visits per year	100% after deductible
<i>Chiropractor</i>	In Network: \$20 copay Out of Network: Deductible & Coinsurance	\$25 copay	100% after deductible