Effective January 1, 2024

Contract College Health Plan Comparison Chart

While every attempt has been made to ensure the accuracy of this summary, in the event of any discrepancy, the Summary Plan Description and Plan Document will prevail.

Plan Features*	HMO Blue-CNY	MVP-CNY (HMO)	Empire Plan Participating Providers	Empire Plan Non-Participating Providers
Deductible (per calendar year)	None	None	None	$1250 Per Enrollee $1250 Per Spouse/Domestic Partner and $1250 all Dep. Children Combined
Lifetime Maximum	Unlimited	Not applicable	Unlimited	Unlimited
Out-of-Pocket Max. per calendar year (does not include deductible)	$6350 Individual $12,700 Family	$6,350 Individual $12,700 Family	***Medical $2,600 Individual Medical $5,200 Family Rx $1,400 Individual Rx $2,800 Family	**$3750 Per Enrollee, $3750 Per Spouse/Domestic Partner and $3750 all Dep. Children Combined
Preventive, Routine, and Specialty Care				
Routine Physical Exams	No copay	No copay	No cost ($25 copay may apply; some tests have age limitations)	Employee or spouse/domestic partner: No coverage under age 50; over 50 covered at100%; not subject to ded. or coinsurance
Hearing Exams	$40, once every 12 months for routine	$25 (specialist)	$25 Copay	Included in hearing aid coverage
Hearing Aids	No cost: up to 2 hearing aids every 3 calendar years for children up to age 19	Not covered	No network benefit	Up to $1500 per hearing aid per ear (every 4 years)
Eye Exams	Routine: Not Covered Diagnostic: $40 specialist copay	Routine exam $25 copayevery 2 years/Diagnostic specialist $25 copay	Not covered: routine	Not covered: routine
Immunizations	No cost	No cost	No cost for select preventative immunizations. (Vaccines received by participating pharmacies in CVS network are covered for patients age 18 or older)	Not covered
Allergy Treatment	Testing and injections- $25 (PCP), $40 (specialist)/visit	No cost	$25 Copay for office visit injections: No cost	80% after deductible [1]
Physician Visits/Diagnostic	$25 (PCP), $40 (specialist)	No cost ($25 specialist)	$25 Copay	80% after deductible
Telehealth	$25 (PCP); $40 (Specialist); (100% using MD Live)	PCP no copay / specialist $25 (Gia app no copay)	$25 (PCP); (100% using LiveHealth Online)	80% after deductible
Pediatric Care (To Age 19)				
Well Child Visits	No Cost	No cost	No cost	80% after deductible
Immunizations	No Cost	No cost	No cost (Incl. influenza vaccine)	80% after deductible
Sick Visits	$25 (PCP), $40 (specialist)	No cost ($25 specialist)	$25 Copay	80% after deductible
Routine Newborn Care	No Cost	No cost	No cost	Unlimited: Not subject to deductible or coinsurance
Women's Health Care/OB-GYN				
Pap Tests*	No cost (routine)	No cost	$50 (hospital), $25 (office)	80% after deductible
Mammograms*	No cost (routine)	No cost	No cost (office)	80% after deductible
Bone Density Tests	$40	No cost	$50 (hospital), $25 (office)	80% after deductible
Gynecology Visits*	No cost (routine)	No cost	No cost	80% after deductible
Pre- and Post-Natal Visits	No cost	$25 for initial visit only	No cost	80% after deductible
Hospital Delivery	Physician: lesser of $200 copay or 20% coinsurance	No cost	No cost	90% Charges reimbursed
Nursery Charges	No cost	No cost	No cost	90% Charges reimbursed
Infertility Services	$25 (PCP), $40 (specialist), applicable facility copayment	$25 (specialist)	$25 copay or no cost if received at a center of excellence (precert. req.); $50,000 Lifetime max	80% of the allowed amount after deductible: $50,000 Lifetime max
Contraceptive Drugs & Devices	No cost for certain drugs/devices, otherwise applicable Rx copay applies	No cost	No cost: Generic and drugs without a generic equivalent	80% of the allowed amount after deductible
Diagnostic & Therapeutic Services/Outpatient				
X-Ray	$40	$25	$25 Copay (Dr. office or participating lab); $50 Copay (hospital); Pathology has no hospital co-pay	80% of the allowed amount after deductible (Dr. office or nonpar lab); employee pays 10% of charges or $75 whichever is greater (hospital)
Lab Tests	No cost	No cost		
Pathology	No cost	No cost		
EKG/EEG	$40	$25		
Radiation/Chemotherapy	$25	$25	No cost	80% of the allowed amount after deductible (Dr. office or nonpar lab); employee pays 10% of chargesor $75 whichever is greater (hospital)

Plan Features*	HMO Blue-CNY	MVP-CNY (HMO)	Empire Plan Participating Providers	Empire Plan Non-Participating Providers
Hospital Care/Inpatient				
Semi-Private Room	No cost	No cost	No cost	90% of charges reimbursed
Private Room if Medically Necessary	No cost	No cost	No cost: Isolation	90% of charges reimbursed
Physician Services	Physician surgery: Lesser of $200 copay or 20% coinsurance	No cost	No cost	80% of R&C after deductible
Radiation/Chemotherapy	$25	$25	No cost	90% of charges reimbursed
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered
Anesthesiology, Pathology, Radiology	No cost	No cost	100% Coverage	100% Coverage
Transplant Services	No copayment at designated center of excel (auth. req.)	No cost	No copayment at designated centers of excellence (precertification required)	80% of allowed amount after deductible
Hospital Alternatives				
Skilled Nursing Facility	No cost: Max 45 days	No cost: Max 45 days	No cost: 120 day max (precertification required)	10% of billed charges up to the combined annual coinsurance maximum
Home Health Care	No cost: Max 40 visits	$25/visit	HCAP no cost (network)	50% Network allowance after deductible
Hospice Care	No cost: Max 210 Days	No cost: Max 210 days	No cost	Inpatient: 10% coinsurance; outpatient: 10% coinsurance of $75, whichever is greater
Worldwide Emergency Care				
At Home "After Hours" (ER)	$100-waived if admitted	$75/visit	$100 Copay: Waived if admitted	80% of R&C after deductible
When You Travel (ER)	$100-waived if admitted	$75/visit	$100 Copay: Waived if admitted	80% of R&C after deductible
Walk-in Center	$35	$15/visit	$30 Copay: $100 if billed as ER	80% of R&C after deductible
Ambulance - Medically Necessary	$100 (includes air ambulance)	$50 per trip	$70 Copay	$70 Copay
Mental Health Services				
Inpatient	No cost; unlimited days	No cost; unlimited days	Carelon - No Cost - No Max Days	90% After deductible
Outpatient	$25 Copay; unlimited days	$25 copay; unlimited days	Carelon - $25 Copay - No Max Visits	80% After deductible
Alcohol/Drug Abuse Services				
Detoxification	No cost, unlimited days	No copay, unlimited days	Carelon, No cost	90% after deductible
Inpatient Rehab - Alcohol	No cost, unlimited days	No copay, unlimited days	Carelon, No cost	90% after deductible
Inpatient Rehab - Drug	No cost, unlimited days	No copay, unlimited days	Carelon, No cost	90% after deductible
Outpatient Rehab	$25 copay; unlimited days	$25 copay, unlimited days	Carelon - $25 copay; Max 20 visit Substance Use Family Therapy	80% after deductible. Max 20 visit Substance Use Family Therapy
Rehabilitative Care				
Physical Therapy: Outpatient	$40 copay; Max 30 visits (combined physical, speech & occupational)	$25 copay; Max 30 visits (combined physical, speech, & occupational)	At hospital–after hospitalization: $25 copay; At physical therapy office $25 copay; under MPN program	$250 Deductible: 50% network allowance
Chiropractic Therapy	$40	$25	$25 copay; no max	$250 deductible; 50% network allowance
Speech Therapy: Short Term to Restore Normal Speech (with Significant Clinical Improvement)	$40 copay: Max 30 visits (combined physical, speech & occupational)	See physical therapy	HCAP: No cost Participating provider: $25 Copay	80% of the allowed amount after deductible
Durable Medical Equipment & Supplies	50% Coinsurance	50% Coinsurance	HCAP: No cost	50% of network reimbursement after deductible
Prosthetics and Orthotics	50% Coinsurance	50% Coinsurance	No cost	80% of the allowed amount after deductible
Prescription Drugs/Outpatient				
Retail – up to a 30 Day Supply (generic/preferred/nonpreferred)	$10/$30/$50	$0 Generic/$30/$50	$5/$30/$60	Non-par. Pharmacy: AWP less appropriate tier copay
Retail – up to a 90 Day Supply (generic/preferred/nonpreferred)	Not applicable	Not applicable	$10/$60/$120	Non-par. Pharmacy: AWP less appropriate tier copay
Mail Order – up to a 90 Day Supply	$20/Generic; $60/Preferred brand name; $100/Non-preferred brand name: Up to 90 day supply	$0/Generic; $75/Preferred brand name; $125/Non-preferred brandname	$5/Generic; $55/Preferred brand name; $110/Non-preferred brand name	Non-participating pharmacy: Average wholesale price less appropriate tier copay
Diabetic Supplies	$25 per 30 day supply (incl. insulin and oral agents)	$15 copay, $100 max for a 30-day supply. $0 copay up to age 26	Equipment: No cost under HCAP program; Insulin covered under Rx program	Equip: 50% of network reimb. after deductible; Insulin: AWP less appropriate tiercopay under Rx

(1) Based on 275% of the Medicare rates published by the Centers for Medicare & Medicaid Services (CMS)
* Age and maximum limits in this column pertain to HMO Blue-CNY coverage only.
**Empire plan out-of-pocket max does not cross apply

Updated 12/02/2023