NYP Medical Plans
Empire BlueCross BlueShield

Medical		
Plan Provision	**Exclusive Provider Organization (EPO) & Point of Service**	**Point of Service (POS)**
	In-Network Services (POS)	**Out-of-Network Services**
Primary Care Physician	No Primary Care Physician Required	No Primary Care Physician Required
Deductible Individual Family	Not Applicable Not Applicable	**Salary <$30K $30K<$50K $50K<$70K $70K+** Individual $200 $300 $500 $750 Family $500 $750 $1,250 $1,875
Co-Insurance	Not Applicable	30%
Annual Out-of-Pocket Maximum Individual Family	Not Applicable Not Applicable	**Salary <$30K $30K<$50K $50K<$70K $70K+** Individual $3,000 $3,000 $3,000 $4,500 Family $7,500 $7,500 $7,500 $11,250
Lifetime Maximum	Unlimited	Unlimited
In-Patient Hospital	Covered at 100%	Subject to deductible and 30% co-insurance
Physician's Care	Covered at 100% after co-pay* per visit	Subject to deductible and 30% co-insurance
Preventive Care	Covered at 100% for routine physicals, well-women and well-child care to age 19	Subject to deductible and 30% co-insurance
Radiology Services	Covered at 100% after co-pay* per visit	Subject to deductible and 30% co-insurance
Emergency Services	$50 co-payment (waived if admitted within 24 hours)	$50 co-payment (waived if admitted within 24 hours)
Maternity	Covered at 100%	Subject to deductible and 30% co-insurance
Infertility Treatment	Covers infertility treatment for medically necessary diagnostic tests and certain procedures	Covers infertility treatment for medically necessary diagnostic tests and certain procedures
In-Vitro Fertilization (IVF)	Not Applicable	Total lifetime maximum of $12,500 Services are covered only if provided by NYP: Weill Cornell, (646) 962-3709 Presbyterian/Columbia, (646) 756-8282
Mental Health Services ***(Precertification Required for in-patient services only)***	Covered at 100% $30 co-pay* per visit	Subject to deductible and 30% co-insurance Subject to deductible and 30% co-insurance
Substance Abuse Services ***(Precertification Required)***	Covered at 100%; 30 days/year rehabilitation, unlimited detox Covered at 100%	Subject to deductible and 30% co-insurance; 30 days/year rehabilitation, unlimited detox Subject to deductible and 30% co-insurance
Physical Therapy Services **(*Precertification Required*)** In-Patient Out-Patient	Covered at 100%, 30 days/year $30 co-pay* per visit; 60 visits/year	Subject to deductible and 30% co-insurance Not Applicable
Vision Care Plan Blue View Vision	Vision exam, lenses for glasses, frames, contact lenses (in lieu of lenses and frames): covered once every 24 months; co-pays apply.	Limited services; contact Empire
Prescription Plan CVS Caremark	Retail: Initial 30 day prescription and one refill $10 Generic; $30 Brand Name (formulary); $60 Brand Name (non-formulary) Mail Order: 90 day prescription for maintenance medication $20 Generic; $60 Brand Name (formulary); $120 Brand Name (non-formulary)	No Out-of-Network
Co-pay* = $25 if salary is less than $70,000		
Co-pay = $30 if salary is equal to or greater than $70,000		