UFT WELFARE FUND

SUMMARY COMPARISON OF HEALTH PLANS FOR EMPLOYEES AND THOSE RETIREES NOT ELIGIBLE FOR MEDICARE

RATES AS OF JULY 2021. SUBJECT TO CHANGE.

	TYPE OF PLAN	PPO/INDEMNITY	HMO	POS	EPO	GATED EPO	HMO	OAP-OPEN ACCESS PLAN	HMO	HMO
	NAME OF PLAN	*GHI-CBP	HIP HMO Gold Preferred Plan (Grandfathered)	HIP PRIME POS	EMPIRE EPO	EMPIRE BLUE ACCESS GATED EPO	AETNA INC. EPO	***CIGNA HEALTHCARE	VYTRA	*GHI/HMO
	MONTHLY COST RATES EFFECTIVE 7/1/21 (SUBJECT TO CHANGE)	BASIC COVERAGE: $0 EMPLOYEE OPTION** Individual: $4.14 Family: $10.47 RETIREE OPTION** Individual: $76.08 Family: $139.49	BASIC COVERAGE:$0 RETIREE OPTION* Individual: $311.25 Family: $762.56	BASIC ONLY* Individual: $1,178.87 Family: $2,888.24 BASIC WITH RETIREE OPTION Individual: $1,517.21 Family: $3,717.18	BASIC ONLY Individual: $1,028.87 Family: $2,613.81 BASIC WITH RETIREE OPTION Individual: $1,337.30 Family: $3,369.95	BASIC ONLY Individual: $303.30 Family: $911.23 BASIC WITH RETIREE OPTION Individual: $611.73 Family: $1,667.37	BASIC ONLY Individual: $419.13 Family: $1,721.06 BASIC WITH RETIREE OPTION Individual: $2,405.42 Family: $7,338.94	BASIC ONLY Individual: $989.81 Family: $2,671.08 BASIC WITH RETIREE OPTION Individual: $1,298.70 Family: $3,605.71	BASIC ONLY Individual: $189.81 Family: $648.44 BASIC WITH RETIREE OPTION Individual: $556.79 Family: $1,603.17	BASIC ONLY Individual: $239.17 Family: $690.51 BASIC WITH RETIREE OPTION Individual: $669.54 Family: $1,788.13
	PHONE NUMBER	GHI: 212-501-4444 BC: 800-433-9592	833-CNY-GOLD/833-269-4653	800-447-8255	800-767-8672	833-924-1055	800-445-8742	800-244-6224	866-409-0999	877-244-4466
	WEBSITE	www.emblemhealth.com/city www.empireblue.com/nyc	www.emblemhealth.com	www.emblemhealth.com	www.empireblue.com		www.aetnanycity.com	www.cigna.com	www.emblemhealth.com	www.emblemhealth.com/city
OVERVIEW	**MEDICAL/SURGICAL • In-Network or Participating Provider**	Participating provider's services provided at no cost except $15 co-payment for office visits to Medical Providers/Practitioners. $30 for Surgeons, all Surgical Subspecialties and Dermatologists (a full list appears on www.emblemhealth.com).	Preferred provider, No co-pay. Non-preferred PCP $0 co-pay	In network: $10 PCP co-pay $15 Specialist co-pay. Out of network: Covered 70% after deductible.	$15 co-pay.	$15 co-pay.	Covered in full minus co-pays as specified below.	$15 per visit or $25.	Full coverage when services are provided or approved by an in network primary physician except for co-payments as specified below. No referrals needed for OB/GYN, Podiatrists, Chiropractors, Ophthalmologists or Mental Health Providers.	Full coverage when services are provided or approved by a GHI/HMO primary physician except for co-payments as specified below.
OVERVIEW	**• Out-of-Network or Non-Participating Provider Deductible**	$200 deductible per person ($500 per family) per calendar year.	Not applicable.	$750 annual deductible per person ($2,250 for a family).	In-network benefits only.	In-network benefits only.	Not applicable.	Emergency care only.		
OVERVIEW	**Co-Insurance/Schedule**	After deductible met, GHI pays 100% of the NYC Non-Participating Provider Schedule of Allowances. (Note: Schedule does not represent current provider charges.) If you have the Optional Rider, the Rider will provide for an average 75% increase in existing NYC Schedule of Allowances for in-hospital and related procedures.	Preferred provider No co-pay. Non-preferred PCP $10 copay	70% of the customary charges as determined by HIP. Customary charges are based on nationally recognized fee schedule. Patient responsible for 30% plus charges in excess of customary charge.	Not applicable. In-network benefits only.	Not applicable. In-network benefits only.	Not applicable.	100%.		
OVERVIEW	**Stop Loss/Catastrophic**	If you use non-participating physicians for in-hospital care, you may incur catastrophic expenses. GHI Catastrophic Coverage pays additional amounts under such circumstances. When you have, in a calendar year, $1,500 in covered out-of-pocket expenses, GHI pays 100% of the catastrophic allowed charge as determined by GHI. The services to which Catastrophic Coverage applies and also the services which contribute to the $1,500 deductible are: surgery, anesthesia, maternity care, in-hospital medical care, radiation, chemotherapy and expenses related to in-hospital X-ray and laboratory services.	No limit in network.	After $3,000 co-insurance per person ($9,000 for family) payment at 100% of customary charges. Charges in excess of covered charges remain the patient's responsibility.	Not applicable. In-network benefits only.	Not applicable. In-network benefits only.	Not applicable.	Annual out-of-pocket maximum: Individual: $2,000. Family: $4,000.		
OVERVIEW	**Maximums**	Unlimited.	Unlimited.	In-network: Unlimited. Out-of-network: Unlimited.	Unlimited.	Unlimited.	None.	Unlimited lifetime maximum.		
OVERVIEW	**Notification and/or Approval**	No notification or approval required to go Out-of-Network.	Referrals Needed for specialists Preferred provider No co-pay. Non-preferred PCP $10 co-pay	Must contact plan prior to going out of network for certain services (hospital, skilled nursing, ambulatory surgery, home care, MRIs, CAT scans).	Precertification required for inpatient admission; home health care; home infusion therapy; physical therapy; occupational therapy; hospice; skilled nursing; speech therapy; cardiac rehab; MRI; MRA; durable medical equipment; inpatient & outpatient surgery; maternity; air ambulance.	PCP referral required for specialist visit. Precertification by PCP required for inpatient admission; home health care; home infusion therapy; physical therapy; occupational therapy; hospice; skilled nursing; speech therapy; cardiac rehab; MRI; MRA; durable medical equipment; inpatient & outpatient surgery; maternity; air ambulance.	None.	No referrals. Notify Cigna within 48 hours for emergency.		
OVERVIEW	**Sample Restrictions (POS Plan)**	Not applicable.	Not applicable.	In-network benefits only.	In-network benefits only.	In-network benefits only.	None.	Not applicable.		
OVERVIEW	**HOSPITALIZATION • In-Network or Participating Provider**	In-Network hospital: After $300 co-pay per admission ($750 per person per calendar year maximum). For employees and non-Medicare retirees: Full 365 days covered by Blue Cross under basic. New York City Healthline must be contacted to avoid penalty of $250 per day to a maximum of $500 per admission prior to any scheduled hospital admission and within 48 hours of emergency admission. Out-of-Network hospital: $500 co-pay per visit per admission and 20% coinsurance and balance billing.	Covered in full. $100 co-pay. Centers of Excellence: Hospital for Special Surgery and Memorial Sloan Kettering Cancer Center $0 co-pay	In-network: $100 co-pay per admission. Out-of-network: Covered 70% after deductible.	As many days as medically necessary, semi-private room & board covered in full with prior precertification from Empire's Medical Management and subject to co-pay of $250 individual/maximum $625 per calendar year per contract.	As many days as is medically necessary. Semiprivate room and board. $300 co-payment per admission	$300 hospitalization co-pay.	$150 per admission.		
OVERVIEW	**• Out-of-Network or Non-Participating Provider**		Not applicable.		In-network benefits only.	In-network benefits only.	Not covered.	Emergency care only. Hospital emergency room, $50 per visit. Waived if admitted. If admitted the $150 inpatient co-pay would apply.	Emergency services only	Emergency admissions covered in full.
	IN-HOSPITAL SPECIALIST CONSULTATION	Payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances. Limited to one per specialty per confinement for each condition. Covered only upon referral of your provider.	Covered in full.	In network: Included in hospital admission co-pay. Out-of-network: Covered 70% after deductible.	All services covered in full with prior precertification from Empire's Medical Management and subject to co-pay of $250 individual/ maximum $625 per calendar year per contract for any inpatient admission.	All services covered in full with prior precertification from your PCP by Empire's Medical Management and subject to co-pay of $250 individual/ maximum $625 per calendar year per contract for any inpatient admission.	Covered in full.	No charge.	Covered in full.	Covered in full.
	SURGERY (In or out of hospital)	Payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances. Mandatory Healthline notification required for surgical procedures. In-network, Blue Cross covers outpatient facility charges after 20% coinsurance (maximum of $200 per individual per calendar year). Out-of-network, you pay $500 co-pay per person per visit/admission and 20% coinsurance per person. You may be responsible for the charges that exceed the out-of-network reimbursement by Empire Blue Cross Blue Shield combined with the remaining deductible and coinsurance amounts.	$50 co-pay ambulatory. Inpatient $150 co-pay.	In-network: $100 co-pay ambulatory surgery. Out-of-network: Covered 70% after deductible.			Covered in full. Outpatient surgery center co-pay $75.	$15 or $25 in physicians office.	$0 co-pay for ambulatory surgery inpatient covered in full.	Covered in full.
	ASSISTANT AT SURGERY	Schedule of Allowances.	Covered in full.	In-network: Included in hospital admission co-pay. Out-of-network: Covered 70% after deductible.			Covered in full.	No charge.	Covered in full when medically necessary.	Covered in full.
	IN-HOSPITAL ANESTHESIA	Payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Covered in full.				Covered in full after $300 co-pay.	No charge.	Covered in full.	Covered in full.
	MATERNITY AND RELATED CARE	Blue Cross covers mother's hospital stay after $300 co-pay. For most other charges, GHI payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances. See Newborn Well-Baby Nursery Charges below.	Covered in full.				In-network: $15 co-pay for first OB visit only. $300 hospitalization co-pay.	First visit to confirm pregnancy, $15 or $25. Per visit thereafter, no charge. Hospital charges per admission, $150. Delivery charges, none.	$0 co-pay.	In-network: First visit $15 co-pay OB/GYN visits. Hospital covered in full.
	NEWBORN WELL-BABY NURSERY CHARGES	Initial in-hospital pediatric visit payment in full for participating providers. Reimbursement for non-participating is covered up to a $60 maximum per confinement.	Covered in full.				Covered in full.	Covered in full.	Covered in full.	Covered in full if added to plan/contract within 30 days.
	NEWBORN WELL-BABY MEDICAL CARE	Eleven out-of-hospital visits covered from birth through 23 months. Ages 2-19: One out-of-hospital visit per year according to the New York State Department of Health Guidelines.	Covered in full: Infusion Therapy, High Tech Radiology, Diagnostic Testing, Doctor's office: $0 co-pay preferred, $10 non-preferred. Hospital inpatient: $10 copay (preferred and nonpreferred.)	In network: No co-pay. Out-of-network: Covered 70% after deductible.			No co-pay.	Covered in full.	Covered in full.	Covered in full.
	PREVENTIVE CARE (Including Well-Child Care & Immunization)	Immunizing agents relative to adult vaccinations for influenza and pneumonia covered in full with no co-pay for office visit. Covered only when rendered by CBP participating provider. For non-Medicare eligible employees and their eligible dependents, GHI-CBP will provide for annual physical through CBP participating providers only with no co-pay. No co-pay for lab and diagnostic radiological services when completed in office of exam. Outside lab or radiological subject to provisions of $20 co-pay currently in effect for lab and diagnostic X-rays. Well-child care & immunization: GHI will provide necessary immunizations as recommended by the American Academy of Pediatrics for hepatitis A, varicella and pneumococcal conjugate vaccine (Prevnar).	Covered in full, including routine physicals.	In-network: No co-pay. Out-of-network: subject to deductible & coinsurance.	Covered in full. No co-pay.	Covered in full. No co-pay.	In-network routine physicals, routine GYN exams, mammograms, well-child care covered in full.	Dependent preventive care (birth to age 19), well child care physical exams, routine immunizations and injections; no charge for office visit.	No co-pay.	Covered in full. Nutritional counseling: $15 co-pay, two visits. Acupuncture: $15 co-pay, up to six visits.
	OFFICE VISIT	Payment in full for participating providers. $15 co-payment for office visits to Medical Providers/ Practitioners. $30 for Surgeons, all Surgical Subspecialties and Dermatologists (a full list appears on www.emblemhealth.com). Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Preferred provider No co-pay. Non-preferred PCP $10 co-pay.	In-network: $10 co-pay. Out-of-network: Covered 70% after deductible.	Covered in full In-network with $15 co-pay.	Covered in full In-network with $15 co-pay for PCP and Specialist	$15 co-pay to PCP. $20 specialists when seen with referral from PCP.	$15 or $25 per visit.	$5 co-pay.	Covered in full with $15 co-pay.
	SPECIALIST CONSULTATION — OUT-OF-HOSPITAL	Payment in full for participating providers except for $30 co-payment for office visits to Medical Providers/ Practitioners. $30 for Surgeons, all Surgical Subspecialties and Dermatologists (a full list appears on www.emblemhealth.com). Reimbursement for non-participating is covered under NYC Schedule of Allowances. Limited to one per specialty per year for each condition. Covered only upon referral of your provider.	Preferred provider No co-pay. Non-preferred PCP $10 co-pay.	In-network: $15 co-pay. Out-of-network: Covered 70% after deductible.	Covered in full In-network with $15 co-pay.	Covered in full In-network with $15 co-pay and PCP referral.	Covered in full with $20 co-pay.	$25 per visit. Women have direct access to a participating OB/GYN for well-woman gynecological care and acute gynecological conditions.	Covered in full with $5 co-pay with referral from PCP.	Covered in full — $15 co-pay with a referral from PCP.
	X-RAYS AND LABORATORY TESTS	Payment in full for participating providers except for $20 co-payment. A maximum of one co-payment for these services will apply per date of service, per provider. Reimbursement for non-participating is covered under NYC Schedule of Allowances. MRI/CAT/Hitech Radiology - $50	Preferred provider No co-pay. Non-preferred PCP $10 co-pay. Not included in office visit co-pay.	In-network: Included in PCP office co-pay. Out-of-network: Covered 70% after deductible.	Covered in full In-network with no co-pay.	Covered in full In-network with no co-pay.	Covered in full. $20 co-pay may apply.	Covered in full at In-network facility.	Included in PCP office visit co-pay	Lab tests covered in full. X-rays: $15 co-pay.
	PRIVATE DUTY NURSING	In network: No out-of-pocket expenses for covered services. Precertification by GHI's Managed Care Department is required. Out of network: 80% of participating provider schedule of allowances after $250 deductible per person per calendar year. No maximum.	Supplemental Welfare Fund benefit for employees: No coverage first 72 hours. Reimbursed at 80% for up to 504 subsequent hours in hospital.**	In-network: Covered in full. Not covered Out-of-network. Supplemental Welfare Fund benefit for employees, as described under HIP Prime.**	Not covered.	Not covered.	Covered in full when medically necessary and approved and coordinated through Aetna.	Covered in full when medically necessary and approved by Cigna.	Covered in full on in-patient basis only when medically necessary.	Not covered.
	AMBULANCE SERVICE	Coverage at 80% of GHI's schedule of allowances.	To hospital covered in full (no co-pay).	In-network: No co-pay. Out-of-network: Same as in-network coverage.	No co-pay up to allowed amount. You pay difference between allowed amount and total charge.	No co-pay up to allowed amount. You pay difference between allowed amount and total charge.	Covered in full when medically necessary.	Emergency care per ride, no charge.	No co-pay.	Covered in full when medically necessary.
	EMERGENCY SERVICE	After $150 co-payment, emergency room covered by Blue Cross for sudden or serious illness or accidental injury. Co-pay waived if admitted to hospital. Empire also covers the emergency room physicians and non invasive pathology, radiology and cardiology services rendered in the emergency room.	$150 co-pay waived if admitted.	In-network: $100 co-pay. Out-of-network: Same as in-network coverage.	$35 co-pay waived if admitted within 24 hours.	$35 co-pay waived if admitted within 24 hours.	Covered anytime, anywhere in the world, 24 hours a day, 7 days a week. $75 co-pay for emergency room visit (waived if admitted). $300 hospitalization co-pay.	$50 co-pay for outpatient emergency room visit. No charge if hospitalized. Physician's office, $15 or $25 co-pay.	ER co-pay $25 waived if admitted. Urgent Care subject to PCP co-pay not to exceed $35.	$35 co-pay. Waived if admitted. Must notify GHI/HMO within 48 hours.
	OUT-OF-AREA CARE AND/OR TRAVEL COVERAGE	Benefits are paid without regard to any geographical limitations.	Out-of-area care applies to emergency service only.	Subject to deductable and coinsurance.	Access to over 668,000 providers and 8,500 hospitals nationwide participating in the Blue Card® PPO Program. BlueCard® Worldwide provides health care coverage for members traveling in Europe, Caribbean, Latin America, Asia, South Pacific, Africa and the Middle East.	Urgent and emergency care is available to members nationwide through Empire's BlueCard® program's traditional provider network. Guest membership is available to HMO members living in another city for at least 90 days through local Blue Cross and/ or Blue Shield plans. Guest membership is available to Blue Access Gated EPO members living in another city for at least 90 days through local Blue Cross and/or Blue Shield plans	Worldwide emergency care coverage as described above.	Emergency room care as previously described. Emergency hospitalization is covered. $150 co-pay.	Emergency Services only.	Emergency room care as previously described. Emergency hospitalization is covered.
	SKILLED NURSING FACILITY	Covered by Blue Cross subject to NYC Healthline pre-authorization. A maximum of 90 days coverage for skilled nursing facility care which may include 30 inpatient days in a rehabilitation hospital primarily for physical therapy, physical rehabilitation or physical medicine. One acute rehab day is equal to two days in a skilled nursing facility.	Covered in full unlimited days. No co-pay.	In-network: No co-pay unlimited days per calendar year. Out-of-network: Not covered.	Covered in full up to 60 days per calendar year. Precertification by Empire's Medical Management Program is required.	Up to 60 days per calendar year. $100 co-payment per admission	Covered in full when medically necessary in lieu of hospitalization and when coordinated through Aetna after $300 co-pay.	Inpatient health care facilities such as skilled nursing and rehabilitation, up to 60 days per contract year: No co-pay.	No co-pay. 45 days per calendar year.	Covered in full 120 days per year.
	ROUTINE PODIATRIC CARE	Not covered except as prescribed for metabolic diseases, such as diabetes, then payment in full for participating providers except for $30 co-payment for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Not covered.	Not covered.	Not covered.	Not covered.	Covered in full with $20 co-pay, for diabetics only.	Routine care of the feet not covered.	Routine foot care not covered except when patient is diabetic.	Routine care of the feet not covered.
	ALLERGY TESTING AND ALLERGY TREATMENTS	Payment in full for participating providers except for $30 co-payment for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances. More than 30 visits subject to medical review by GHI.	Preferred provider No co-pay. Non-preferred PCP $10 co-pay.	In-network: $15 co-pay. Out-of-network: Covered 70% after deductible.	Covered in full In-network with $15 co-pay (waived for treatments).	Covered in full In-network with $15 co-pay (waived for treatments).	Covered in full with $20 co-pay.	$15 or $25 per visit.	Allergy testing and treatment covered in full with $5 co-pay.	$15 co-pay with PCP referral.
	CHIROPRACTIC CARE	Payment in full for participating providers except for $15 co-payment for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances. Coverage is unlimited, subject to medical review.	Preferred provider: No co-pay. Non-preferred PCP: $10 co-pay.	In-network: $15 co-pay. Out-of-network: Covered 70% after deductible.	Covered in full In-network with $15 co-pay (when medically necessary).	Covered in full In-network with $15 co-pay (when medically necessary). PCP referral required.	Covered in full with $20 co-pay. Also, access to Choose Healthy™ Program, which provides negotiated discounted fees for chiropractic manipulation.	$15 or $25 per visit.	Subject to specialist office visit co-pay	$15 co-pay with PCP referral when medically necessary.
	RADIATION THERAPY	Payment in full to participating providers. Reimbursement for non-participating covered under NYC Schedule of Allowances.	Included in hospital admission co-pay.	In-network: Included in hopital admission co-pay. Out-of-network: Covered 70% after deductible.	Covered in full In-network. No co-pay.	Covered in full In-network. No co-pay.	Covered in full with $20 co-pay.	Outpatient, no charge.	No co-pay (inpatient). $5 co-pay for initial visit only (outpatient).	Covered in full.
	VISITING NURSE SERVICE	Payment in full to participating providers. Precertification by GHI's Managed Care Department is required. Up to 200 visits per year. Non-participating providers are covered subject to $50 deductible per episode; 80% of Schedule of Allowances. Maximum of 40 visits per calendar year.	200 visits per calendar year. No co-pay.	In-network: No co-pay 200 visits per calendar year. Out-of-network: Covered 70% after deductible.	Covered in full In-network up to 200 visits per calendar year under home health care. Precertification by Empire's Medical Management Program is required.	Covered in full In-network up to 200 visits per calendar year under home health care. Precertification by your PCP through Empire's Medical Management Program is required.	Covered when medically necessary. Covered in full when coordinated through Aetna's Patient Management Dept.	Home health care per use, no charge. No coverage for conditions for which there is not a reasonable expectation of significant improvement through short-term treatment. HOSPICE CARE: No co-pay.	$5 co-pay. 40 visits per calendar year.	Covered in full for 40 visits only, when medically necessary.
	PHYSICAL THERAPY	Payment in full for participating providers except $20 co-payment for office visits. Reimbursement for nonparticipating is covered under NYC Schedule of Allowances. More than 16 visits subject to medical review by GHI. Precertification required when in the MD office, outpatient facility or free standing facility after 16 visits per calendar year.	Preferred provider: No co-pay. Non-preferred PCP: $10 co-pay. 90 visits.	In-network: $15 co-pay, 90 visits per calendar year. Out-of-network: Covered 70% after deductible.	Inpatient covered In-network in full up to 30 days per calendar year. Outpatient covered In-network combined 30 visits in home, office, outpatient facility per calendar year. Precertification by Empire's Medical Management is required. $15 co-pay home or office.	$300 co-payment per admission (up to 30 inpatient days per calendar/plan year)	In-network inpatient covered in full under hospitalization or skilled nursing facility benefit. In-network outpatient covered in full minus $20 co-pay. Treatment covered over 60-day consecutive period per incident of illness or injury beginning with first day of treatment.	Short-term rehabilitation and physical therapy combined 60 visits maximum per contract year, $15 or $25 co-pay. No coverage for conditions for which there is not a reasonable expectation of significant improvement through short-term treatment.	Subject to specialist office visit co-pay.	$15 co-pay, 30 visits per 60-day period.
	APPLIANCES	Subject to separate annual deductible of $100 per person** when using GHI preferred provider panel. If non-panel, 50% reimbursement of allowed charge after deductible. Equipment in excess of $2,000 must be preauthorized by GHI.	Retiree: Durable Medical Equipment including crutches, canes, wheelchairs, commodes and walkers, through rider. In-Service: Additional Welfare Fund benefit reimbursed at 80% of reasonable charge, subject to $25 deductible, $1,500 annual maximum and $3,000 lifetime.**	In-network: No annual deductible. Not covered Out-of-network. In-Service: Supplemental Welfare Fund benefit for employees, as described under HIP Prime.	Durable medical equipment, medical supplies, prosthetics, orthotics covered in full. Precertification by Empire's Medical Management is required. In-network provider only.	50% coinsurance	Covered in full. Coverage for durable medical equipment must be deemed medically necessary and is subject to the approval of and coordination through Aetna's Patient Management Dept.	Appliances is $200 deductible. No Limit. External Prosthetic Appliances (EPA) Plan pays 100%. $200 EPA annual deductible. Annual Limit: Unlimited	$0 annual deductible (prior authorization required).	80% covered to an annual maximum of $1,500.
	ALCOHOLISM AND DRUG ABUSE (Chemical Dependency)	Outpatient: In-network: Unlimited visits subject to a $15 co-pay; Out-of-Network: Unlimited visits subject to City of NY non-participating Schedule of Allowances; annual deductible: $200 individual/ $500 family; 100% coinsurance; no lifetime maximum. Inpatient: In-network: 365 days for Detoxification and Rehabilitation; subject to deductible: $300 per admission/ $750 maximum per calendar year; Out-of-Network: 365 days of Detoxification and Rehabilitation; subject to deductible: $500 per admission/ $1,250 maximum per calendar year. Hospital: Provider must call ValueOptions for prior approval if hospital is In-network. Member must call ValueOptions if a non-par hospital. Failure to call will result in a penalty of $250 per day up to a maximum of $500 and claim is subject to retrospective review by ValueOptions. Medical: There are no precertification requirements for par or nonpar outpatient services except for outpatient psychological testing.	Subject to hospital admission co-pay – no limit on days per calendar year. Outpatient: No co-pay for preferred provider. Non-preferred PCP $10 co-pay.	In-Network: Inpatient: $100 co-pay. Outpatient: $10 co-pay unlimited visits per calendar year. Out-of-Network: Covered 70% after deductible.	Outpatient visits office or facility: $15; Inpatient Care* (as many days as medically necessary; semi private room and board) $250/$625 per admission per calendar year per contract. *Pre approval & authorization required by Empire's Behavioral Healthcare Management Program.	$15 co-pay in office, $0 co-pay outpatient visits in a facility, $300 copayment per admission (as many days as medically necessary, semiprivate room and board)	Detoxification covered in full for acute phase of treatment for In-network inpatient after $300 co-pay. In-network outpatient covered in full with $15 co-pay.	Inpatient substance use disorder: $150 per admission copay, and plan pays 100%. Outpatient substance use disorder: Physcian's Office: $15 copay, and plan pays 100%. Outpatient substance use disorder: all other services: Plan pays 100%	Outpatient drug and alcohol treatment $5 co-pay; Unlimited days per calendar year. Inpatient rehabilitation covered in full; Unlimited days per calendar year. Inpatient detoxification, covered in full. Unlimited days per calendar year.	Inpatient: Detox covered in full. Rehabilitation covered in full. Outpatient: $15 co-pay per visit.
	OUTPATIENT PSYCHIATRIC CARE	Outpatient Psychiatric Care: In-network: Unlimited visits subject to a $15 co-pay; Out-of-Network: Unlimited visits subject to NYC non-participating Schedule of Allowances; annual deductible: $200 individual/ $500 family; 100% coinsurance; no lifetime maximum. No prior approval required, except for outpatient psychological testing for both in-network or out-of-network providers. Note: Inpatient substance abuse benefits that used to be included in the Optional Rider are now part of the basic benefit.	Inpatient: Subject to hospital admission co-pay: Unlimited days per calendar year. Preferred provider No co-pay. Non-preferred PCP $10 co-pay.	In network: $10 co-pay unlimited days per calendar year. Out of Network: Covered 70% after deductible.	Outpatient visits office or facility: $15; Inpatient Care* (as many days as medically necessary; semi private room and board) $250/$625 per admission per calendar year per contract. *Pre approval & authorization required by Empire's Behavioral Healthcare Management Program.	$15 co-pay in office, $0 co-pay outpatient visits in a facility, $300 co-payment per admission (as many days as medically necessary, semiprivate room and board)	Precertification required. $20 co-pay per visit.	Inpatient mental health: $150 per admission copay and plan pays 100%. Outpatient mental health: Physcian's Office: $25 copay, and plan pays 100%. Outpatient mental health: all other services: Plan pays 100%	Inpatient: Covered in full; Unlimited days per calendar year; unlimited biologically based mental illness and serious childhood emotional disorders. Outpatient: $5 co-pay; Unlimited visits per calendar year; unlimited biologically based mental illness and serious childhood emotional disorders.	Inpatient: Covered in full. Outpatient: $15 co-pay.
	DEPENDENT CHILDREN	Covered to age 26.	Covered to age 26.	Covered to age 26.	Covered to age 26.	Covered to age 26.	Covered to age 26.	Covered to age 26.	Covered to age 26.	Covered to age 26.

*Please note, at the time of printing, the July 1, 2021 rates have not yet been finalized. The rates will be published on our website once finalized. **Additional Welfare Fund benefits. See Red Apple. ***Benefits in California and Arizona may differ. See City Summary Program Description for complete details.
This chart is a general outline of benefits provided and is not the contract. Refer to appropriate booklets for contactual provisions.

PLEASE POST