

## Newburgh Enlarged City School District

Benefit Category	NYS Empire Plan		GHI HMO Select \$25 VALUE PLUS PLAN	CDPHP AvidCare 25	MVP Co-Plan \$20 Plus
	In-Network	Out-of-Network			
<b>Primary Care Physician</b>	No PCP Required	No PCP Required	PCP Required	PCP Required	PCP Required
<b>Referral Requirement</b>	No	No	Yes	Yes	No
<b>Pre-Certification</b>	required for certain benefits including admissions, MRI's, Substance Abuse, Mental/Nervous	required for certain benefits including admissions, MRI's, Substance Abuse, Mental/Nervous	Yes	No	No
<b>Deductible</b>	No	\$375 Individual \$750 Dep/Chd \$1125 Family	No	No	No
<b>Out-of-pocket maximum</b>	None	\$1033 Exclusive of deductible amount	None	None	None
<b>Lifetime maximum</b>	Unlimited	\$1,000,000 Annual per year	Unlimited	Unlimited	Unlimited
<b>HOSPITAL BENEFITS:</b>					
<b>Inpatient:</b>					
<b>Semi-Private Room</b>	Covered in full up to 365 days per confinement	Covered at 90% up to 365 days per confinement up to \$1500 annually	Covered in full for unlimited number of days	Covered in full for unlimited number of days	Covered in full for unlimited number of days
<b>Mental/ Nervous</b>	Covered in full for unlimited days as long as pre-certified and approved	Covered at 50% of reasonable & customary charges for 30 Days	Covered in full for up to 30 days per year.	Covered in full for up to 30 days per year.	Covered in full for up to 30 days per year.
<b>Alcohol/Substance</b>	Covered in full for unlimited days as long pre-certified and approved	Covered at 50% of reasonable & customary charges up to a \$50,000 maximum payout per individual	Covered in full for up to 7 days	Covered in full for up to 30 days	Covered in full for up to 7 days
<b>HOSPITAL BENEFITS:</b>					
<b>Outpatient:</b>					
<b>Emergency</b>	Covered in full after \$70 Co-pay	Covered in full after \$70 Co-pay	Covered in full after \$100 Co-pay	Covered in full after \$100 Co-pay	Covered in full after \$50 Co-pay
<b>Surgery</b>	Covered in full after \$60 Co-pay	Covered in full after \$60 Co-pay	Covered in full after \$75 Co-pay	Covered in full after \$25 Co-pay	Covered in full after \$20 Co-pay
<b>Lab/X-Ray</b>	Covered in full after \$40 Co-pay	Covered in full after \$40 Co-pay	Covered in full after \$25 Co-pay	Covered in full \$25 Co-pay (waived at designated sites)	Lab-Covered in Full X-ray-\$20 Co-pay
<b>Pre-Admission Testing</b>	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
<b>Chemotherapy</b>	Covered in full	Covered in full	Covered in full	Covered in full after \$25 Co-pay	Covered in full \$20 Co-pay
<b>Radiation</b>	Covered in full	Covered in full	Covered in full	Covered in full after \$25 Co-pay	Covered in full \$20 Co-pay
<b>Mammography</b>	Covered in full after \$40 Co-pay	Covered in full after \$40 Co-pay	Covered in full	Covered in full	Covered in full
<b>Cervical Cancer Screening</b>	Covered in full	Covered in full	Covered in full	Covered in full after	Covered in full \$20 Co-pay

<b>MEDICAL BENEFITS:</b>					
<b>Office Visits</b>	Covered in full after \$20 Co-pay	Paid at 80% of reasonable & customary charges after \$375 Deductible	Covered in full after \$25 Co-pay (\$35 Urgent Care Co-Pay)	Covered in full after \$25 Co-pay	Covered in full after \$20 Co-pay
<b>Annual Physicals</b>	\$20 Co-pay	Up to \$250 for active ee's age 50 or older and up to \$250 for active ee's covered spouse or domestic partner age 50 or older	Covered in full after \$25 Co-pay	Covered in full	Covered in full after \$20 Co-pay
<b>Well Child Care</b>	Covered in full	up to \$150	Covered in full	Covered in full	Covered in full
<b>Well Woman Care</b>	Covered in full after \$20 Co-pay	Paid at 80% of reasonable & customary charges after \$375 deductible	Covered in full	Covered in full	Covered in full after \$20 Co-pay
<b>Inpatient Visits</b>	Covered in full	Paid at 50% of reasonable & customary charges after \$375 deductible	Covered in full	Covered in full	Covered in full
<b>Maternity</b>	Covered in full after initial visit and \$20 Co-pay	Paid at 50% of reasonable & customary charges after \$375 deductible	Covered in full	Covered in full after initial visit	Covered in full after initial visit
<b>Surgery</b>	Covered in full	Paid at 80% of reasonable & customary charges after \$375 deductible	Covered in full after \$25 Co-pay	Covered in full	Covered in full after \$20 Co-pay
<b>Assistant Surgery</b>	Covered in full	Paid at 80% of reasonable & customary charges after \$375 deductible	Covered in full after \$25 Co-pay	Covered in full	Covered in full
<b>Anesthesiology</b>	Covered in full	Paid at 80% of reasonable & customary charges after \$375 deductible	Covered in full	Covered in full	Covered in full
<b>Lab/X-Ray</b>	Covered in full after \$20 Co-pay	No Coverage	Covered in full after \$25 Co-pay	Covered in full after \$25 Co-pay	Covered in full after \$20 Co-pay
<b>Mental - Inpatient</b>	Covered in full - unlimited	Covered at 50% of reasonable & customary charges up to 30 visits	Covered in full (30 visits)	Covered in full (30 visits)	Covered in full after \$45 Co-pay (30 visits)
<b>Mental - Outpatient</b>	Covered in full - unlimited	Covered at 50% 30 visits	Covered in full after \$25 Co-pay 20 visits	Covered in full after \$30 Co-pay 30 visits	Covered in full after \$35 Co-pay 20 visits
<b>Physical Therapy/OT</b>	\$20 Co-pay	No Coverage	Covered in full after \$25 Co-pay 30 visits within 60 days	Covered in full after \$25 Co-pay up to 120 days each per diagnosis per year	Covered in full after \$20 Co-pay 30 visits referral required

<b>Durable Medical and Prosthetics</b>	Covered in full	No Coverage	Covered at 80% up to \$10,000 maximum annual payout	Covered at 80%	Covered at 50%
<b>Chiropractic</b>	Covered in full after \$20 Co-pay	Covered at 50% of reasonable & customary charges after \$250 deductible \$1500 annual Max	Covered in full after \$25 Co-pay	Covered in full after \$25 Co-pay Referral required	Covered in full after \$20 Co-pay
<b>Vision Exam</b>	Not Covered	Not Covered	Covered in full after \$25 Co-pay (every 12 months)	Covered in full after \$25 Co-pay	Covered in full after \$20 Co-pay (every 24 months)
<b>PRESCRIPTIONS:</b>					
<b>Retail</b>	Covered in full after a \$5 generic and \$15 name brand Co-pay, \$40 non-formulary Co-Pay up to a 30 day supply	Covered up to network allowance	Covered in full after \$10 generic and \$20 name brand, \$30 non-formulary Co-pay for up to a 30 day supply	Covered in full after \$10 generic and \$30 name brand, \$50 non-formulary Co-pay for up to a 30 day supply	Covered in full after \$10 generic and \$30 name brand, \$50 non-formulary Co-pay for up to a 30 day supply
<b>Mail Order</b>	90 Day supply - covered in full after \$5 Generic, \$20 Name Brand, \$65 Non Formulary Co-Pay	No Coverage	90 Day supply - covered in full after two month Co-pay	90 Day supply - covered in full after two 1/2 month Co-pay	Up to 90 Day supply - covered in full after two month Co-pay