



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

RATES AS OF JANUARY 2019. SUBJECT TO CHANGE.

OVERVIEW

TYPE OF PLAN	PPO/INDEMNITY	HMO	POS	HMO	HMO	HMO	HMO	HMO	HMO	
NAME OF PLAN	GHI-CBP	HIP PRIME	HIP PRIME POS	EMPIRE EPO	EMPIRE HMO	AETNA INC. EPO	CIGNA HEALTHCARE**	VYTRA	GHI/HMO	
<b>MONTHLY COST</b> RATES EFFECTIVE 1/1/19 (SUBJECT TO CHANGE)	<b>BASIC COVERAGE: \$0</b> <b>EMPLOYEE OPTION*</b> Individual: \$5.21 Family: \$13.20 <b>RETIREE OPTION*</b> Individual: \$77.19 Family: \$140.74	<b>BASIC COVERAGE:\$0</b> <b>RETIREE OPTION</b> Individual: \$239.00 Family: \$585.56	<b>BASIC ONLY</b> Individual: \$1,092.43 Family: \$2,676.39 <b>BASIC WITH RETIREE OPTION</b> Individual: \$1,377.78 Family: \$3,375.51	<b>BASIC ONLY</b> Individual: \$700.89 Family: \$1,789.05 <b>BASIC WITH RETIREE OPTION</b> Individual: \$935.89 Family: \$2,365.16	<b>BASIC ONLY</b> Individual: \$379.27 Family: \$1,095.23 <b>BASIC WITH RETIREE OPTION</b> Individual: \$614.27 Family: \$1,671.34	<b>BASIC ONLY</b> Individual: \$241.42 Family: \$1,134.61 <b>BASIC WITH RETIREE OPTION</b> Individual: \$1,795.71 Family: \$5,530.68	<b>BASIC ONLY</b> Individual: \$797.15 Family: \$2,160.33 <b>BASIC WITH RETIREE OPTION</b> Individual: \$1,089.71 Family: \$3,033.44	<b>BASIC ONLY</b> Individual: \$101.20 Family: \$400.32 <b>BASIC WITH RETIREE OPTION</b> Individual: \$380.52 Family: \$1,126.72	<b>BASIC ONLY</b> Individual: \$144.72 Family: \$441.63 <b>BASIC WITH RETIREE OPTION</b> Individual: \$467.51 Family: \$1,264.60	
<b>PHONE NUMBER</b>	GHI: 212-501-4444 BC: 800-433-9592	800-447-8255			800-767-8672		800-445-8742	800-244-6224	800-406-0806	877-244-4466
<b>WEBSITE</b>	www.emblemhealth.com/city www.empireblue.com	www.emblemhealth.com			www.empireblue.com		www.aetnacity.com	www.cigna.com	www.vytra.com	www.emblemhealth.com/city
<b>MEDICAL/SURGICAL</b> • <b>In-network or Participating Provider</b>	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 \$10 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.			
<b>Out-of-Network or Non-Participating Provider Deductible</b>	\$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.			
<b>Co-insurance/ Schedule</b>	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 co-pay.	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%.			
<b>Stop Loss/ Catastrophic</b>	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 customary 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.			
<b>Maximums</b>	Unlimited.	Unlimited.	In-network: Unlimited. Out-of-network: Unlimited.	Unlimited.	Unlimited.	None.	Unlimited lifetime maximum.			
<b>Notification and/or Approval</b>	No notification or approval required to go Out-of-Network.	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).	Pre-certification required for inpatient admission; home health care; home infusion therapy; physical therapy; occupational therapy; hospice; skilled nursing; speech therapy; cardiac rehab; MRI; durable medical equipment; inpatient & outpatient surgery; maternity; air ambulance.	Pre-certification by PCP required for inpatient admission; home health care; home infusion therapy; physical therapy; occupational therapy; hospice; skilled nursing; speech therapy; cardiac rehab; MRI; durable medical equipment; inpatient & outpatient surgery; maternity; air ambulance.	None.	No referrals. Notify Cigna within 48 hours for emergency.			
<b>Sample Restrictions (POS Plan)</b>	Not applicable.	Not applicable.	In-network benefits only.	In-network benefits only.	In-network benefits only.	None.	Not applicable.			
<b>HOSPITALIZATION</b> • <b>In-network or Participating Provider</b>	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 HealthCare 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.	In-network: \$100 co-pay. Out-of-network: Covered 70% after deductible.	As many days as medically necessary, semi-private room & board covered in full with prior pre-certification from Empire's Medical Management and subject to co-pay of \$250 individual/maximum \$625 per calendar year per contract.	As many days as medically necessary, semi-private room & board covered in full with prior pre-certification by PCP from Empire's Medical Management and subject to co-pay of \$250 individual/maximum \$625 per calendar year per contract.	\$300 hospitalization co-pay.	\$150 per admission.			
<b>Out-of-Network or Non-Participating Provider</b>	Not applicable.	Not applicable.	In-network benefits only.	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.			
<b>IN-HOSPITAL SPECIALIST CONSULTATION</b>	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 pre-certification 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 pre-certification 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.	
<b>SURGERY (In or out of hospital)</b>	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 covered in full.	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.	Outpatient surgery in provider's office covered in full with \$5 co-pay.	Covered in full.	
<b>ASSISTANT AT SURGERY</b>	Schedule of Allowances.	Covered in full.				Covered in full.	No charge.	Covered in full when medically necessary.	Covered in full.	
<b>IN-HOSPITAL ANESTHESIA</b>	Payment in full for participating providers. Reimbursement for non-participating is covered under NYC Schedule of Allowances.	Covered in full.	In-network: Included in hospital admission co-pay.			Covered in full after \$300 co-pay.	No charge.	Covered in full.	Covered in full.	
<b>MATERNITY AND RELATED CARE</b>	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.	Out-of-network: Covered 70% after deductible.			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.	
<b>NEWBORN WELL-BABY NURSERY CHARGES</b>	Initial in-hospital pediatric visit payment in full for participating providers. Reimbursement for non-participating is covered up to a \$40 maximum per confinement.	Covered in full.				Covered in full.	Covered in full.	Covered in full.	Covered in full.	
<b>NEWBORN WELL-BABY MEDICAL CARE</b>	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.	In-network: No co-pay. Out-of-network: Covered 70% after deductible.			No co-pay.	Covered in full.	Covered in full.	Covered in full.	
<b>PREVENTIVE CARE (Including Well-Child Care &amp; Immunization)</b>	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 GHI participating provider. For non-Medicare eligible employees and their eligible dependents, GHI will provide for annual physical through GHI participating providers only with no co-pay. No co-pay for lab and diagnostic radiological services when completed in office of exam. 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.	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.	
<b>OFFICE VISIT</b>	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.	\$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.	
<b>SPECIALIST CONSULTATION — OUT-OF-HOSPITAL</b>	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.	
<b>X-RAYS AND LABORATORY TESTS</b>	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/Hecht Radiology - \$50	Preferred provider No co-pay. Non-preferred PCP \$10 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.	X-rays covered in full as part of office visit. Lab tests covered in full. X-rays: \$15 co-pay.	Lab tests covered in full. X-rays: \$15 co-pay.	
<b>PRIVATE DUTY NURSING</b>	In-network: No out-of-pocket expenses for covered services. Pre-certification 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: Not covered. First 72 hours. Reimbursed at 80% for up to 504 subsequent hours in hospital.*	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 inpatient basis only when medically necessary.	Not covered.	
<b>AMBULANCE SERVICE</b>	Coverage at 80% of GHI's schedule of allowances.	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.	
<b>EMERGENCY SERVICE</b>	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.	\$5 co-pay for emergency care in doctor's office or participating urgent center. \$25 co-pay for emergency care of hospital. Waived if admitted.	\$35 co-pay. Waived if admitted. Must notify GHI/HMO within 48 hours.	
<b>OUT-OF-AREA CARE AND/OR TRAVEL COVERAGE</b>	Benefits are paid without regard to any geographical limitations.	Out-of-area care applies to emergency services only. Call 1-800-447-8255.	Subject to deductible and coinsurance.	Access to over 668,000 providers and 8,500 hospitals nationwide participating in the Blue Cross PPO Program. BlueCross® Worldwide benefits 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 BlueCross 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.	Worldwide emergency care coverage as described above.	Emergency room care as previously described. Emergency hospitalization is covered. \$150 co-pay.	Emergency room care as previously described. Emergency hospitalization is covered.	Emergency room care as previously described. Emergency hospitalization is covered.	
<b>SKILLED NURSING FACILITY</b>	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 therapy. 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: Covered 70% after deductible.	Covered in full In-network up to 60 days per calendar year. Pre-certification by Empire's Medical Management Program is required.	Covered in full In-network up to 60 days per calendar year. Pre-certification by PCP from Empire's Medical Management Program is required.	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.	
<b>ROUTINE PODIATRIC CARE</b>	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 diabetic only.	Routine care of the feet not covered.	Routine care of the feet not covered except when patient is diabetic.	Routine care of the feet not covered.	
<b>ALLERGY TESTING AND ALLERGY TREATMENTS</b>	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.	
<b>CHIROPRACTIC CARE</b>	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.	Covered in full when medically necessary with \$5 co-pay.	\$15 co-pay with PCP referral when medically necessary.	
<b>RADIATION THERAPY</b>	Payment in full for participating providers. Reimbursement for non-participating covered under NYC Schedule of Allowances.	Included in hospital admission co-pay.	In-network: Included in hospital 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.	
<b>VISITING NURSE SERVICE</b>	Payment in full for participating providers. Pre-certification 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. Pre-certification by Empire's Medical Management Program is required.	Covered in full In-network up to 200 visits per calendar year under home health care. Pre-certification 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.	
<b>PHYSICAL THERAPY</b>	Payment in full for participating providers except for \$20 co-payment for office visits. Reimbursement for non-participating is covered under NYC Schedule of Allowances. More than 16 visits subject to medical review by GHI.	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. Pre-certification by Empire's Medical Management is required. \$15 co-pay home or office.	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.	\$5 co-pay. Short-term rehabilitation only (two consecutive months).	\$15 co-pay. 30 visits per 60-day period.		
<b>APPLIANCES</b>	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.	Refuse: 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. Pre-certification by Empire's Medical Management is required. In-network provider only.	Durable medical equipment, medical supplies, prosthetics, orthotics covered in full. Pre-certification by your PCP through Empire's Medical Management is required. In-network provider only.	Covered in full. Coverage for durable medical equipment must be deemed medically necessary and subject to the approval of and coordination through Aetna's Patient Management Dept.	Short-term rental/purchase of certain durable medical equipment: no charge when approved by Cigna physician. Initial purchase/fitting of certain external prosthetic devices when approved by Cigna physician. Covered up to \$1,000 per contract year after \$200 deductible. Durable medical equipment covered in full.	Covered in full when medically necessary and obtained through a VYTRA designated vendor. Prior authorization required.	80% covered to an annual maximum of \$1,500.	
<b>ALCOHOLISM AND DRUG ABUSE (Chemical Dependency)</b>	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-panel 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 pre-certification requirements for per or non-panel outpatient services except for outpatient psychological testing.	Subject to hospital admission co-pay — no limit on days per calendar year. Outpatient: No co-pay. Preferred provider No co-pay. Non-preferred PCP \$10 co-pay.	In-network: Inpatient: No 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.	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.	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.	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.	*Substance abuse detoxification services available as inpatient or outpatient, depending on necessity. Services provided by national network of Psychological Managed Care Consultants who evaluate patient needs, provide treatment and coordinate counseling and therapy. Inpatient: \$150 co-pay per admission, unlimited days per contract year. Outpatient Individual: Unlimited days per contract year. Outpatient Group: Unlimited days per contract year. \$25 co-pay per session.	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.
<b>OUT-PATIENT PSYCHIATRIC CARE</b>	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 with unlimited biological based mental illness and serious childhood emotional disorders. Outpatient: Preferred provider No co-pay. Non-preferred PCP \$10 co-pay.	In-network: \$15 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.	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.	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.	Services provided by CIGNA Behavioral Health. Inpatient: \$150 co-pay per admission unlimited days per contract year. Outpatient Individual: \$25 co-pay/session unlimited days per contract year. Outpatient Group Therapy: Unlimited days per contract year. Structured group programs as authorized by Cigna: \$25 co-pay per session.	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.	
<b>DEPENDENT CHILDREN</b>	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.	

\*Additional Welfare benefits. See Red App.

\*\*Benefits in California and Arizona may differ. See City Summary Program Description.

