FUND FOR THE CITY OF NEW YORK

Group Policy Number 218835	Empire Blue Cross/Blue Shield	Empire Blue Cross/Blue Shield	Empire Blue Cross/Blue Shield		Empire Blue Cross/Blue Shield	
Effective May 1, 2023	EPO HSA	PRISM	Direct PPO PLAN A -Low		PPO PLAN B - HIGH	
	In-Network	In-Network Only (there are no out-of-network benefits)	In-Network	Out of Network	In-Network	Out of Network
Deductible	$1,500/$3,000	$0/ $0	$0/ $0	$5,000/$12,500	N/A	$2,000/$5,000
Out-of-Pocket Max	$3,000/$6,000	$5,000/$12,500	$5,080/$12,700	$17,500/$43,750	$5,080/$12,700	$14,000/$35,000
Co-Insurance	0%	0%	0%	50%/50%	N/A	60%/40%
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
HOME/OFFICE/OUTPATIENT CARE						
Office Copay	Deductible	$35 PCP/ $50 Specialist	$30 PCP/ $50 Specialist	Deductible + 50%	$25 PCP/$40 Specialist	40% after Deductible
ER Copay	Deductible	$100 Copay, waived if admitted	$100 Copay, waived if admitted		$75 Copay, waived if admitted	
Urgent Care Copay	Deductible	$50 copay	$35 copay	$35 copay	$35 copay	$35 copay
Covered Preventive Care	100%	100%	100%	Deductible + 50%	100%	40% after Deductible
WebVisit (LiveHealth)	Deductible	$17.50 copay per online consultation	$15 copay per online consultation	Covered in-network only	$12.50 copay per online consultation	Covered in-network only
Routine Maternity Care	Deductible	100%	100%	Deductible + 50%	100%	40% after Deductible
Ambulatory/Outpatient Surgery	Deductible	$100 copay	$100 copay	Deductible + 50%	$75 Copay	40% after Deductible
Physical Therapy (up to 30 visits)	Deductible	$35/$50 copay	$30/$50 copay	Deductible + 50%	$25/$40 copay	40% after Deductible
Speech/Language, Occupational, Vision Therapies (up to 30 visits)	Deductible	$35/$50 copay	$30/$50 copay	Deductible + 50%	$25/$40 copay	40% after Deductible
Outpatient Cardiac Rehabilitation	Deductible	$50 copay	$50 copay	Deductible + 50%	$25/$40 copay	40% after Deductible
Second Surgical Opinion	Deductible	$35/$50 copay	$30/$50 copay	Deductible + 50%	$25/$40 copay	40% after Deductible
INPATIENT CARE						
Hospital Inpatient	Deductible	$500 per admission	$500 per admission	Deductible + 50%	$500 per admission	40% after Deductible
Surgical Fees	Deductible	100%	100%	Deductible + 50%	100%	40% after Deductible
Physical Therapy, Physical Medicine or Rehabilitation (up to 30 inpatient days per calendar year)	Deductible	$500 per admission	$500 per admission	Deductible + 50%	$500 per admission	40% after Deductible
Skilled Nursing Facility (up to 120 days)	Deductible	$500 per admission	100%	Deductible + 50%	100%	40% after Deductible
MENTAL HEALTH						
Inpatient Care (as many days as medically necessary)	Deductible	$500 per admission	$500 per admission	Deductible + 50%	$500 per admission	40% after Deductible
Outpatient Visits in Office	Deductible	$35 Copay	$30 Copay	Deductible + 50%	$25 copay	40% after Deductible
Outpatient Visits in Facility	Deductible	100%	100%	Deductible + 50%	100%	40% after Deductible
SUBSTANCE ABUSE						
Inpatient Detoxification (as many days as medically necessary)	Deductible	$500 per admission	$500 per admission	Deductible + 50%	$500 per admission	40% after Deductible
Inpatient Rehabilitation	Deductible	$500 per admission	$500 per admission	Deductible + 50%	$500 per admission	40% after Deductible
Outpatient Visits in Office	Deductible	$35 Copay	$30 Copay	Deductible + 50%	$25 copay	40% after Deductible
Outpatient Visits in Facility	Deductible	100%	100%	Deductible + 50%	100%	40% after Deductible
OTHER						
Home Health Care	Deductible	200 visits @ 100%	200 visits @ 100%	Deductible + 50%	200 visits @ 100%	40% after Deductible
Hospice Care	Deductible	Unlimited Days Per Lifetime @ 100%	210 Days Per Lifetime @ 100%	Deductible + 50%	210 Days Per Lifetime @ 100%	40% after Deductible
Medical Supplies	Deductible	100% (when obtained through Empire's medical supplies vendor)	100% (when obtained through Empire's medical supplies vendor)	Deductible + 50%	100% (when obtained through Empire's medical supplies vendor)	40% after Deductible
Durable Medical Equipment	Deductible	50%	100%	Deductible + 50%	100%	40% after Deductible
PRESCRIPTION DRUGS						
Prescription Deductible (Tiers 2 and 3 Only)	Combined w/ Medical	$100/ $200	$100/$200	In Network Only	$50	In Network Only
Retail (up to 30 days)	$10/$35/$70	$10/$35/$70	$10/$35/$70		$10/$35/$70	
Mail Order (up to 90 days)	$20/$70/$140	$20/$70/$140	$20/$70/$140		$20/$70/$140	
Annual Maximum	Combined w/ Medical	Combined w/ Medical	Combined w/ Medical		Combined w/ Medical	
Mandatory Generic	No	No	No		No	
EMPLOYEE CONTRIBUTIONS						
Individual	$80/paycheck; $1,920 annual	$100/paycheck; $2,400 annual	$139/paycheck; $3,336 annual		$248/paycheck; $5,952 annual	
Employee + Spouse/DP	$150/paycheck; $3,600 annual	$178/paycheck; $4,272 annual	$279/paycheck; $6,696 annual		$480/paycheck; $11,520annual	
Employee + Child(ren)	$140/paycheck; $3,360 annual	$160/paycheck; $3,840 annual	$251/paycheck; $6,024 annual		$460/paycheck; $11,040 annual	
Family	$200/paycheck; $4,800 annual	$225/paycheck; $5,400 annual	$310/paycheck; $7,440 annual		$532/paycheck; $12,768 annual	