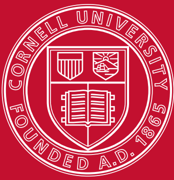

Cornell University
Division of Human Resources

Effective July 1, 2009

Contract College Health Plan Comparison Chart

Plan Features**	HMO Blue-CNY	Empire Plan Participating Providers	Empire Plan Non-Participating Providers
Deductible (per calendar year)	None	None	$363 Per Enrollee; $363 Per Spouse/Domestic Partner; $363 Per All Dependent Children Combined.
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Out-of-Pocket Max. per calendar year (does not include deductible)	N/A	N/A	$1000 $1500 Nonparticipating hospitals
Preventive, Routine & Specialty Care			
Routine Physical Exams	$10	$20 Copay	Employee or Spouse: No Coverage Under Age 50; Over 50-$250/Year
Hearing Exams	$40	$20 Copay	Inclusive in Hearing Aid Coverage Below.
Hearing Aids	$600 coverage every 3 calendar years for children until age 19	No Current In-Network Providers	$1500 per hearing aid per ear (every 4 years)
Eye Exams	No benefit; discount program	Not Covered	Not Covered
Immunizations	No Cost	$20 Copay (Includes influenza, pneumococcal pneumonia, measles, mumps, rubella, varicella, tetanus, meningitis)	Not Covered
Allergy Treatment	Testing and injections-$25 (PCP), $40 (Specialist)/Visit	$20 Copay Injections-No cost	80% of R&C After Deductible
Physician Visits/Diagnostic	$25 (PCP), $40 (Specialist)	$20 Copay	80% of R&C After Deductible
Pediatric Care (To Age 19)			
Well Child Visits	No Cost	No Cost	80% of R&C After Deductible
Immunizations	No Cost	No Cost (Includes influenza vaccine)	80% of R&C After Deductible
Sick Visits	$25 (PCP), $40 (Specialist)	$20 Copay	80% of R&C After Deductible
New Born Allowance	No Cost	No Cost	$150-Not Subject to Ded. or Coinsurance
Women's Health Care/OB-GYN			
Pap Tests	$10	$20 Copay	80% of R&C After Deductible
Mammograms	$10	$20 Copay (Dr. Office) $35 Copay (Hospital)	80% of R&C After Deductible
Bone Density Tests	$25	$20 Copay (Dr. Office) $35 Copay (Hospital)	80% of R&C After Deductible
Gynecology Visits (No cost to age 19)	$10	$20 Copay	80% of R&C After Deductible
Pre- and Post-Natal Visits	$5 first 10 Visits	No Cost	80% of R&C After Deductible
Hospital Delivery	Physician: lesser of $200 copay or 20% coinsurance	No Cost	90% charges reimbursed
Nursery Charges	No Cost	No Cost	90% charges reimbursed
Infertility Services	$25 (PCP), $40 (Specialist)	$20 Copay or No Cost if Received at a Center of Excellence (Precertification Required); $50,000 Lifetime Max	80% of R&C After Deductible: $50,000 Lifetime Max
Contraceptive Drugs & Devices	Applicable Rx Copay Applies	$20/Visit	80% of R&C After Deductible
Diagnostic & Therapeutic Services/Outpatient			
X-Ray	$40	$20 Copay (Dr. Office or participating lab); $35 Copay (Hospital)	80% of R&C After Deductible (Dr. Office); employee pays 10% of charges or $75 whichever is greater (Hospital)
Lab Tests	$25	$20 Copay (Dr. Office or participating lab); $35 Copay (Hospital)	80% of R&C After Deductible (Dr. Office or nonpar lab); employee pays 10% of charges or $75 whichever is greater (Hospital)
Pathology	$25	$20 Copay (Dr. Office or participating lab); $35 Copay (Hospital)	80% of R&C After Deductible (Dr. Office or nonpar lab); employee pays 10% of charges or $75 whichever is greater (Hospital)
EKG/EEG	$40	$20 Copay (Dr. Office or participating lab); $35 Copay (Hospital)	80% of R&C After Deductible (Dr. Office or nonpar lab); employee pays 10% of charges or $75 whichever is greater (Hospital)
Radiation/Chemotherapy	$25	No Cost	80% of R&C After Deductible (Dr. Office or nonpar lab); employee pays 10% of charges or $75 whichever is greater (Hospital)

Plan Features**	HMO Blue-CNY	Empire Plan Participating Providers	Empire Plan Non-Participating Providers
Hospital Care/Inpatient			
Semi-Private Room	No Cost	No Cost	90% of charges reimbursed
Private Room if Medically Necessary	No Cost	No Cost-Isolation	90% of charges reimbursed
Physician Services	No Cost	No Cost	80% of R&C After Deductible
Radiation/Chemotherapy	$25	No Cost	90% of charges reimbursed
Private Duty Nursing	Not Covered	Not Covered	Not Covered
Anesthesiology, Pathology, Radiology	$40	100% coverage even through non-par provider	80% of R&C After Deductible
Transplant Services	No Copayment at Designated Ctr of Excel (Auth Req)	No Copayment at Designated Centers of Excellence (Precertification Required); Physician-$20/Visit	80% of R&C After Deductible
Hospital Alternatives			
Skilled Nursing Facility	No Cost-Max 45 days	No Cost-365 Day Max (Precertification Required)	Not Covered
Home Health Care	No Cost (unlimited visits)	HCAP No Cost (Network)	50% Network Allowance After Deductible
Hospice Care	No Cost-Max 210 Days	No Cost-No Max # of Days	Not Covered
Worldwide Emergency Care			
At Home "After Hours" (ER)	$100	$60 Copay if Medical Emergency or Accidental Injury	$60 Copay if Medical Emergency or Accidental Injury
When You Travel (ER)	$100	$60 Copay if Medical Emergency or Accidental Injury	$60 Copay if Medical Emergency or Accidental Injury
Walk-in Center	$35	$20 Copay	80% of R&C After Deductible
Ambulance - Medically Necessary	$100	$35 Copay	$35 Copay
Mental Health Services			
Inpatient	No Cost-Max 30 Days/Year	OptumHealth Network-No Cost-No Max Days	$363 Per Enrollee; $363 Per Spouse/Domestic Partner; $363 Per All Dependent Children Combined, then 80% of R&C after deductible. $1000 Out-of-Pocket Maximum***
Outpatient	$40 copay for up to 20 visits per calendar year	OptumHealth Network-$20 Copay-No Max Visits	80% of R&C after the Mental Health deductible***
Alcohol/Drug Abuse Services			
Detoxification	No Cost, unlimited	OptumHealth Network-No Cost	$2,000 Ded-50% of Reimb to Network Provider
Inpatient Rehab	No Cost-30 Days Alcohol/Year	OptumHealth Network-No Cost-3 Stays Per Lifetime	$2,000 Deductible-50% of Reimb to Network Provider-1 Stay/Year, 3 per Lifetime
	No Cost-30 Days Drug/Year	OptumHealth Network-No Cost-3 Stays Per Lifetime	$2,000 Deductible-50% of Reimb to Network Provider-1 Stay/Year, 3 Per Lifetime
Outpatient Rehab	$25-Max 60 Visits/Year	OptumHealth Network-$20 Copay-No Max Visits	$500 Ded.-50% Reimb to Network Provider-30 Visits Per Year
Rehabilitative Care			
Physical Therapy: Inpatient (with Significant Clinical Improvement)	No Cost-Max 60 Days	No Cost-No Max	90% of charges reimbursed
Physical Therapy: Outpatient	$40 combined limit-Max 30 Visits	At Hospital-After Hospitalization-$20 Copay; At Physical Therapy Office $20 Copay; Under MPN Program	$250 Deductible-50% Network Allowance, and $1,500 Annual Max
Chiropractic Therapy: Required PCP Referral	$40	Same as physical therapy, above	Same as physical therapy, above
Speech Therapy: Short Term to Restore Normal Speech (with Significant Clinical Improvement)	$25 combined limit-Max 60 Visits	HCAP-No Cost Participating Provider-$20 Copay	80% of R&C After Deductible
Durable Medical Equipment & Supplies	50% Reimb Rate	HCAP-No Cost	50% of Network Reimbursement After Deductible
Prosthetics and Orthotics	50% Reimb Rate	No Cost	80% of R&C After Deductible
Prescription Drugs/Outpatient*			
Prescription Drugs Retail - up to a 30 Day Supply	$10/Generic $30/Preferred Brand Name $50/NonPreferred Brand Name	$5/Generic $15/Preferred Brand Name $40/ NonPreferred Brand Name	Non-participating pharmacy - Average Wholesale Price less appropriate tier copay
Prescription Drugs Retail - up to a 90 Day Supply	N/A	$10/Generic $30/Preferred Brand Name $70/NonPreferred Brand Name	Non-participating pharmacy - Average Wholesale Price less appropriate tier copay
Mail Order	$20/Generic $60/Preferred Brand Name $100/NonPreferred Brand Name-Up to 90 Day Supply	$5/Generic $20/Preferred Brand Name $65/NonPreferred Brand Name	Non-participating pharmacy - Average Wholesale Price less appropriate tier copay
Diabetic Supplies	$25/Item(includes insulin) -30 Day Supply	Equipment-No Cost Under HCAP Program; Insulin Covered Under Rx Program	Insulin-Average Wholesale Price less appropriate tier copay Under Rx; Equipment-50% of Network Reimbursement after Ded.

* R&C = Reasonable and Customary

** Age and maximum limits in this column pertain to HMO Blue-CNY coverage only.

*** Non-network Mental Health deductible and Out-of-Pocket Maximums are separate and not combined with any other on Empire Plan

While every attempt has been made to ensure the accuracy of this summary, actual benefit payments are determined by the insurance companies. 7/09