2023 Health Insurance Co-payment Comparison Chart (Rochester Area)
CSEA, UUP, MC, PEF, PBANYS and NYSCOPBA

	EMPIRE PLAN		*Blue Choice*	*MVP*	*Highmark Blue Cross WNY*	*Independent Health*
	Empire BlueCross (Hospital)	*United HealthCare (Medical)*				
	Network	*Participating Provider*				
HOSPITAL SERVICES						
Hospital Inpatient (surgery)	Network: Paid in full		No cost	No cost	No cost	No cost
Hospital Outpatient (surgery)	NetworkHospital $75 or $95 per visit, Participating Provider: $50 per visit		Hospital-$50; Physician's Office- $50 copayment or 20% coinsurance; Outpatient Surgery Facility $40 physician and $50 facility per visit	Hospital/$25, Physician's Office: PCP/$25 , Outpatient Facility $25	Hospital/$100, Physician's Office/$15, Facility/$100	Hospital/$100, Physician's Office/$10 (Primary)$20(Specialist), Facility/$100
Ambulance	No copayment if service is provided by admitting hospital.	Participating Provider- $70/trip.	$100/trip	$50/trip	$100/trip	$100/trip
Emergency Room	$90 or $100/visit	No Copayment	$100/visit	$75/visit	$100/visit	$100/visit
Urgent Care	$40 or $50 per outpatient visit at a hospital-owned urgent care facility only.	$30/visit	$35/visit	$15/visit	$25/visit	$35/visit adult (19+); $0/visit child (0-18)
Skilled Nursing Facility	Precertification Required. No copayment up to 120 benefit days.		No cost: 45 days per admission up to a maximum of 360 lifetime limit	No cost up to 45 days	No cost up to 50 days	No cost up to 45 days
Hospice	No copayment; no limit	No copayment, no limit	No cost; 210 days	No cost, 210 days	No cost	No cost; unlimited

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PHYSICIAN SERVICES						
Office Visit		$25/visit	$25/visit; $5 PCP sick visits for children to age 26, no cost annual exam or well child	$15/visit; no cost for child (0-25)	$10/visit, no cost for child (0-19)	$10/visit, no cost for child (0-18)
Specialty Office Visit		$25/visit	$40/visit	$25/visit	$15/visit	$20/visit
Annual Routine Physical		No Cost	No Cost	No Cost	No cost	No Cost
Chiropractic		$25/visit	Contact Carrier	Contact Carrier	Wellness allowance	Contact Carrier
Family Planning		$25/visit	$25/visit PCP, $40/visit specialist	$25/visit PCP	$15/visit	$20/visit
Infertility Services	$40 or $50 Outpatient	$25/visit; no cost at designated Center of Excellence	Applicable physician/facility copayment	$25/visit PCP	$15/visit	$20/visit (physician's office), $100/visit (outpatient surgery center)

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Contraceptive Drugs/ Devices		No copayment for certain FDA-approved oral contraception methods and counseling	Applicable Rx copay applies - Generic oral contraceptives and certain OTC contraceptive devices are covered in full in accordance with the Affordable Care Act	No cost	No cost	No cost
WOMEN'S HEALTH CARE						
Pap Tests	$40 or $50/outpatient visit	$25 per visit	No cost	No cost	No cost	No cost
Mammograms	No Copayment	No Copayment	No cost	No cost	No cost	No cost
Pre/Post Natal		No Copayment, routione OB utrasounds may be subject to $25 copayment	No cost	No cost	$10/initial visit only, postnatal visits $10 / visit	No cost
Bone Density Tests	$40 or $50/outpatient visit	$25 per visit	No cost for routine visit	No cost	No cost	No cost
DIAGNOSTIC / THERAPEUTIC SERVICES						
Radiology	$40 or $50/outpatient visit	$25/visit	$40/visit	No cost Preferred Provider Facility, $15/PCP $25 Specilaist	$15/visit	$20/visit (office, specialty) $40/visit (hospital)
Lab Tests	$40 or $50/outpatient visit	$25/visit	No cost	No cost	No cost	No cost

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Pathology	No Cost	$25/visit	No cost	No cost	No cost	No cost
EKG/EEG	$40 or $50/outpatient visit	$25/visit	No cost	$25/visit	$15/visit	$10/visit (office, primary); $20/visit (office, specialty) $0/visit child (0-18) in office
Radiation / Chemo	No Cost	No cost	Radiation $25/visit;Chemo $25 Rx Injection and $25 Office copay - max 2/day	Radiation $25/visit; Chemotherapy $15 PCP $25/Specialist	$15/visit	$20/visit (office, specialty) $40/visit (hospital)
MENTAL HEALTH / SUBSTANCE ABUSE						
Inpatient Mental Health		No cost	No cost; unlimited	No cost; unlimited	No cost; unlimited	No cost; unlimited
Outpatient Mental Health		$25/visit	$25/ visit (individual or group); $5 for children to age 26	$15/visit (individual or group); unlimited	$10/visit; unlimited	$10/visit Adult (19+); $0 child (0-18); unlimited

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Inpatient Drug / Alcohol Rehab		No cost	No cost; unlimited	No cost; unlimited	No cost; unlimited	No cost; unlimited
Outpatient Drug / Alcohol Rehab		$25/visit to approved Intensive Outpatient Program.	$25/ visit; $5 for children to age 26	$15/visit; unlimited	$10/visit; unlimited	$10/visit Adult (19+); $0 child (0-18); unlimited
PRESCRIPTION DRUGS						
Prescription Drugs *Note: 3-tier system (generic, preferred brand-name drugs, and non-preferred brand-name drugs)	Mail order, network pharmacy or speciality pharmacy for 30 day supply: $5, $30, or $60. Mail order or speciality pharmacy for 31-90 day supply: $5, $55, or $110. Network pharmacy 31-90 day supply: $10, $60, or $120. *When you fill a prescription for a brand-name drug that has a generic equivalent you pay the non-preferred brand-name co-payment plus the difference in cost between the brand-name drug and its generic equivalent.		30 days retail: $10/$30/$50. 90 days mail order: $20/$60/$100.	30 days retail: $0/$30/$50. 90 days mail order: $0 /$75 /$125	30 days retail: $5/$30/$60. 90 days mail order: $12.50/$75/$150 No cost for preventative, may require approval	Adult (19+) 30 days retail: $5/$30/$60. 90 days mail order:$12.50/$75/$150 ; Child (0-18) 30 days retail: $0/$30/$60. 90 days mail order:$0/$75/$150
MISCELLANEOUS						
Centers of Excellence for Cancer and/or Transplant		No cost at designated Centers of Excellence. Precertification required.	N/A	N/A	N/A	N/A

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Diabetic Supplies		No cost. **Call HCAP for participating providers. Diabetic Shoes $500 annual max**	$25/item; 30 day supply, Diabetic shoes 50% coinsurance	$15 per boxed item (30 day supply); Diabetic shoes 50% coinsurance	$10/item, Diabetic shoes not covered	90 day supply, $0 copayment; Diabetic shoes, $0 copayment Contact carrier insulin
Durable Medical Equipment		No cost. **Call HCAP for participating providers.**	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Orthotics		No copayment	50% coinsurance	50% coinsurance	20% coinsurance	No cost
Prosthetics		No copayment	50% coinsurance	50% coinsurance	20% coinsurance	20% Coinsurance
Rehabilitative Care (PT, OT, Speech)	No copayment as an inpatient; $25 per visit for outpatient physical therapy following related surgery or hospitalization.	Physical or occupational therapy $25 per visit (MPMP) Speech therapy $25 per visit	Inpatient: no cost up to 60 days. Outpatient: $40/visit up to 30 max for all outpatient services combined	Inpatient: no cost, two month max; Outpatient: $15 PCP$25/Specialist up to 30 visits	Inpatient: no cost. Outpatient: $15/visit; max 20 visits.	Inpatient: No cost up to 45 days. Outpatient: $20/visit up to 20 visits per year

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Welness Servicies: Alternative Medicine, Nutrition, Acupuncture, Massage Therapy		Discount for network provider	Up to $500 per family $250 Employee, $250 Spouse/Domestic partner	$600 in WellBeing Rewards	$500 (Single) $600 (family) Wellness card allowance for use at participating providers. Contact for additional programs.	$600 Individual, $750 family. Wellness allowance for use at participating providers. Contact for additional programs
Dental (preventive)		Not covered	$40/when associated with disease or injury	$25/ preventive visit for children up to 19	Not covered	Discount program available
Hearing Aids		No network benefit. See nonparticipating provider.	Children up to age 19 covered in full for up to two hearing aids every three years.	Not covered	$699 copayment per aid for advanced model, $999 copayment per aid for premium model through TruHearing.	Discounts available, contact plan for details
Vision (routine)		Not covered	$40/exam every 2 years, children 0-19 one per year.	$25/exam every 24 months	Discounts Available	No cost/visit once/year