SSSA/TSO Operating & Queens Division/TSO MSII 2024 Health Plan Highlights				
MEDICAL	**AETNA - BASIC POS II OPTION**	**AETNA - SELECT OPTION**	**NYSHIP Empire Plan PPO**	**NYSHIP Emblem Health HMO**
Medical Benefits	In-Network and Out-of-Network Benefits	In-Network Benefits **ONLY**	In-Network and Out-of-Network Benefits	In-Network Benefits **ONLY**
Annual Medical Deductible	$0 In-Network $100 Out-of-Network	$0: In-Network Benefits **ONLY**	$0: In-Network $1,250: Combined Out-of-Network Deductible (Indivdual or Family)	$0: In-Network Benefits **ONLY**
Out-of-Pocket Maximum	No Out-of-Pocket Maximum	No Out-of-Pocket Maximum	$3,200 for Rx Drug Pgm: In-Network Annual Out-of Pocket Maximum (Does <u>not</u> apply to Medicare-primary Enrollees) $5,900 Shared Maximum for Hospital, Medical/Surgical, & Mental Health/Substance Use Pgms (Individual Coverage) $6,400 for Rx Drug Pgm: In-Network Annual Out-of Pocket Maximum $11,800 Shared Maximum for Hospital, Medical/Surgical, & Mental Health/Substance Use	In-Network **ONLY** Annual Out-of Pocket Maximum: $6,850 Individual/Year $13,700 Family/Year
Primary Care Physician (PCP) Referral Requirement	No Referrals Required	No Referrals Required	No Referrals Required	Referrals Required
Annual Preventative Care Visits				
Annual Physical Exams, Well-Woman Visits, & Routine Immunizations & Diagnostic Screenings	$0 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$0 Copay: In-Network Annual Deductible and/or Coinsurance Applies: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**
Routine Well-Child Exams & Immunizations (Up to Age 19)	$0 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$0 Copay: In-Network Annual Deductible and/or Coinsurance Applies: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**
Office Visits (Outside of Annual Preventative Care Visits)				
Primary Care & Specialist Office Visits	$15 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$25 Copay: In-Network Primary & Specialist Visits Annual Deductible and/or Coinsurance Applies: Out-of-Network	$5 Copay: In-Network Primary Care Visits **ONLY** $10 Copay: In-Network Specialist Visits **ONLY**
Hospital Services				
In-patient Hospital Deductible	$50/Confinement Per Person (100% Covered After Deductible Met)	No Deductible (Services Covered At 100%)	No Deductible (Pre-admission Certification Required)	No Deductible (Services Covered At 100%)
Outpatient Hospital Deductible	Included in Medical Deductible (100% Covered After Deductible Met)	No Deductible (Services Covered At 100%)	No Deductible $95 Copay/Visit for In-Network Hospitals | $50 for Participating Providers | $25 Copay/Visit for Participating Provider Offices	No Deductible (Services Covered At 100%)
Emergency Room Services	$100 Copay (Waived if admitted to hospital)	$100 Copay (Waived if admitted to hospital)	$100 Copay (Waived if admitted to hospital)	$75 Copay (Waived if admitted to hospital)
Urgent Care Services	$15 Copay: In-Network $15 Copay: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$30 Copay/Visit: In-Nework Urgent Care Facility $50 Copay/Visit: In-Network Hospital-owned Urgent Care Facilty Annual Deductible and/or Coinsurance Applies: Out-of-	$25 Copay: In-Network Benefits **ONLY**
Family Planning Services	$15 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$0 Copay: In-Network Annual Deductible and/or Coinsurance Applies: Out-of-Network	In-Network Benefits **ONLY**: $5 Copay: Primary Care Visits | $10 Copay: Specialist Visits
Chiropractic Care	$15 Copay with Unlimited Visits & Pre-certification Required After 20th Visit: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$25 Copay: In-Network Annual Deductible and/or Coinsurance Applies: Out-of-Network	$10 Copay: In-Network Specialist Visits **ONLY**
Physical Therapy	$15 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$25/Copay: In-Network $250 Annual Deductible & 50% Coinsurance: Out-of-Network	In-Network Benefits **ONLY**: $0 Copay: Inpatient Care (30 Day Max) | $5 Copay: Outpatient Care $10 Copay: Outpatient Specialist (90 Visit Max on Outpatient Rehab)
Durable Medical Equipment	**Expenses Vary Based on DME Type:** $100 Deductible/Person per Calendar Year: In-Network $100 Deductible/Person per Calendar Year & 50% Coinsurance <u>Plus</u> any Amt Billed Above Allowed Amt: Out-of-Network	In-Network Benefits **ONLY** $100 Deductible/Person per Calendar Year	$0 Copay: In-Network Cost Based on DME Type: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**

Mental Health & Alcohol/Substance Abuse Services				
Mental Health Inpatient Services	$50/Confinement Per Person ($240/Family Max Per Calendar Year): In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$0 Copay: In-Network Facility $1,250 Combined Out-of-Network Annual Deductible (Indivdual or Family) & 90% Coinsurance: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**
Mental Health Outpatient Services	$15 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$25 Copay: In-Network Practitioner $1,250 Combined Out-of-Network Annual Deductible (Indivdual or Family) & 80% Coinsurance: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**
Alcohol/Substance Abuse Inpatient Services	$50/Confinement Per Person ($240/Family Maximum Per Calendar Year): In-Network	$0 Copay: In-Network Benefits **ONLY**	$0 Copay: In-Network $1,250 Combined Out-of-Network Annual Deductible	$0 Copay: In-Network Benefits **ONLY**
Alcohol/Substance Abuse Outpatient Services	$15 Copay: In-Network Based on Allowance Schedule: Out-of-Network	$0 Copay: In-Network Benefits **ONLY**	$25/Day: In-Network (Approved Intensive Outpatient Programs)	$5 Copay: In-Network Benefits **ONLY**
Autism Care				
	$0 Copay: In-Network Physical/Occupational Therapy and Speech/Language Therapy (Unlimited Visits | Medical Necessity Review Conducted After 20 Visits) Based on Allowance Schedule: Out-of-Network	In-Network Benefits **ONLY**: $0 Copay: In-Network Physical/Occupational Therapy and Speech/Language Therapy (90 Visit Maximum per Calendar Year)	$25 Copay: Applied Behavioral Analysis (ABA) Therapy for Autism (Pre-certification Required) NYSHIP's Medical/Surgical and/or Mental Health & Substance Abuse (MHSA) Programs Cover Majority Of Autism Care, Including Assessments, Evaluations, or Tests to Diagnose Autism Spectrum Disorder (ASD), Medications, Assistive Communication Devices, Psychological, Psychiatric, & Therapeutic Care, Inclusive of Services Provided by Licensed Speech Therapists, Occupational Therapists, Social Workers, & Physical Therapists	In-Network Benefits **ONLY**: $10 Copay: Applied Behavioral Analysis (ABA) Therapy for Autism NYSHIP's Medical/Surgical and/or Mental Health & Substance Abuse (MHSA) Programs Cover Majority Of Autism Care, Including Assessments, Evaluations, or Tests to Diagnose Autism Spectrum Disorder (ASD), Medications, Assistive Communication Devices, Psychological, Psychiatric, & Therapeutic Care, Inclusive of Services Provided by Licensed Speech Therapists, Occupational Therapists, Social Workers, & Physical Therapists
PRESCRIPTION DRUGS				
Retail: 30-Day Supply				
Generic	$0 Copay	$0 Copay	$5 Copay	$5 Copay
Formulary Brand	$20 Copay	$20 Copay	$30 Copay	$20 Copay
Non-Formulary Brand	$40 Copay	$40 Copay	$60 Copay	N/A
Mail Order: Up to 90 Day Supply *Mail Order is MANDATORY*				
Generic	$0 Copay	$0 Copay	$10 Copay	$7.50 Copay
Formulary Brand	$40 Copay	$40 Copay	$60 Copay	$30 Copay
Non-Formulary Brand	$80 Copay	$80 Copay	$120 Copay	N/A
Specialty Medication Mail Order: 31-to-90-day Supply via Mail Service or Designated Specialty Pharmacy				
Generic	N/A	N/A	$5 Copay	N/A
Preferrred Brand	N/A	N/A	$55 Copay	N/A
Non-Preferrred Brand	N/A	N/A	$110 Copay	N/A