2025 Health Care Plan Comparison

PLAN FEATURE	ANTHEM BLUE CROSS TRADITIONAL PPO	ANTHEM BLUE CROSS DEDUCTIBLE PPO[1]	CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN (CDPHP)*	INDEPENDENT HEALTH ASSOCIATION (IHA)	MVP	GRADUATE STUDENT AND POSTDOCTORAL PPO PLAN BY BLUE CROSS
POSTDOCTORAL EMPLOYEES BIWEEKLY RATES						
Individual	$93.80	$39.68	$83.15	$69.66	$80.55	$29.08
Individual + Spouse/ Domestic Partner	$294.27	$186.00	$266.09	$264.73	$298.79	$98.31**
Individual + Child(ren)	$239.54	$142.12	$232.83	$181.13	$224.00	
Family	$467.90	$305.69	$382.50	$320.46	$329.80	$136.52
WHAT YOU PAY						
Preventive Care	$0 (gym reimbursement up to $300)	$0 (gym reimbursement up to $300)	$0	$0	$0	$0
Office Visit	$20	$30	$20	$20	$20	$10
Lab	$20	deductible and coinsurance	$20	$0-$20	$20	$15
X-ray	$20	deductible and coinsurance	$20	$20	$20	$15
Emergency Room	$50	$50	$50	$125	$50	$25
Outpatient Surgery	$0	deductible and coinsurance	$75	$15	$75	$15
Durable Medical Equipment	$0 covered in full	deductible and coinsurance	20%	50%	20%	$0 covered in full
Generic Rx	$10	$10	$10	$10	$10	$5
Preferred Rx	$25	$25	$25	$30	$25	$25
Nonpreferred Rx	$45	$45	$45	$50	$40	$45
Mail Order Rx	$10/$50/$90	$10/$50/$90	2.5 copays	2.5 copays	2.5 copays	$5/$50/$90
DEDUCTIBLES						
Inpatient Hospital Services	$100	deductible and coinsurance	$100	$100	$240	$200

[1] *This plan has a $500 in-network individual deductible or $1,250 family deductible and 10 percent coinsurance for services other than an office, urgent care or emergency room visit.*

* *Capital District Physician's Health Plan final 2025 rates were not available at the time of publication. Proposed rates have been provided here. Final rates will be communicated once approved at a later date.*

** *This rate is for Individual plus Spouse or Individual plus One Child. Families with multiple children fall under the Family Tier.*

Your 2025 Dental and Vision Plan Options

2025 Dental Care Plan
Offered through Delta Dental

Covers preventive, basic, major and orthodontic care.

2025 Vision Care Plans
Administered by Davis Vision, Inc.

Basic Vision Plan
Provides a basic level of coverage for eye exams, and eyeglasses or contact lenses.

Vision Plan Plus
Provides an enhanced level of coverage for eye exams, and eyeglasses or contact lenses.

COVERAGE LEVEL	BIWEEKLY RATES	COVERAGE LEVEL	BIWEEKLY RATES	COVERAGE LEVEL	BIWEEKLY RATES
Individual	$1.59	Individual	$0	Individual	$4.85
Family	$7.03	Family	$0	Family	$11.31

For full details, please refer to the RF Benefits Handbook or visit www.rfsuny.org/benefits.