2021 Health Care Plan Rates

For retirees and dependents not Medicare eligible

	ELIGIBLE TO RETIRE BEFORE JANUARY 1, 2012[1]	ELIGIBLE TO RETIRE AFTER JANUARY 1, 2012 FIND YOUR RATES HERE BASED ON YOUR YEARS OF SERVICE AT RETIREMENT.		
SERVICE AT RETIREMENT	**N/A**	**20 OR MORE**	**15 TO 19**	**10 TO 14**
	MEDICARE PART A AND B STATUS: NOT MEDICARE ELIGIBLE			
MONTHLY RATE				
Empire Blue Cross				
Individual	$152.34	$152.34	$253.90	$406.24
Individual + Spouse/DP	$485.18	$485.18	$864.11	$1,349.29
Individual + Child(ren)	$386.58	$386.58	$683.34	$1,069.92
Family	$759.31	$759.31	$1,366.67	$2,125.98
Empire Blue Cross Deductible PPO				
Individual	$70.22	$70.22	$171.78	$324.12
Individual + Spouse/DP	$320.93	$320.93	$699.86	$1,185.04
Individual + Child(ren)	$238.77	$238.77	$535.53	$922.11
Family	$513.19	$513.19	$1,120.55	$1,879.86
Capital District Physicians' Health Plan				
Individual	$127.17	$127.17	$211.94	$339.11
Individual + Spouse/DP	$381.50	$381.50	$678.22	$1,059.71
Individual + Child(ren)	$356.07	$356.07	$631.59	$987.66
Family	$584.96	$584.96	$1,051.23	$1,636.19
Independent Health Association				
Individual	$106.97	$106.97	$178.29	$285.26
Individual + Spouse/DP	$406.50	$406.50	$727.43	$1,133.93
Individual + Child(ren)	$278.13	$278.13	$492.08	$770.21
Family	$492.08	$492.08	$884.32	$1,376.40
MVP				
Individual	$143.85	$143.85	$239.75	$383.60
Individual + Spouse/DP	$593.12	$593.12	$972.05	$1,466.50
Individual + Child(ren)	$419.73	$419.73	$718.54	$1,123.55
Family	$605.00	$605.00	$1,085.19	$1,690.19

[1] *These rates are for retirees who retired or were eligible to retire before January 1, 2012. Retirees who were hired before January 1, 1986 do not contribute to coverage under these rules.*

2021 Health Care Plan Comparison

For retirees and dependents not Medicare eligible

	EMPIRE BLUE CROSS TRADITIONAL PPO	EMPIRE BLUE CROSS DEDUCTIBLE PPO[1]	CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN (CDPHP)	INDEPENDENT HEALTH ASSOCIATION (IHA)	MVP
WHAT YOU PAY					
Preventive Care	$0 (gym reimbursement up to $300)	$0 (gym reimbursement up to $300)	$0	$0	$0
Office Visit	$20	$30	$20	$20	$20
Lab	$20	deductible and coinsurance	$20	$0-$20	$20
X-ray	$20	deductible and coinsurance	$20	$20	$20
Emergency Room	$50	$50	$50	$125	$50
Outpatient Surgery	$0	deductible and coinsurance	$75	$15	$75
Durable Medical Equipment	$0 covered in full	deductible and coinsurance	20%	50%	20%
Generic Rx	$10	$10	$10	$10	$10
Preferred Rx	$25	$25	$25	$30	$25
Nonpreferred Rx	$45	$45	$45	$50	$40
Mail Order Rx	$10/$50/$90	$10/$50/$90	2.5 copays	2.5 copays	2.5 copays
DEDUCTIBLES					
Inpatient Hospital Services	$100	deductible and coinsurance	$100	$100	$240

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

2021 Dental and Vision Plan Rates*

COVERAGE LEVEL	DENTAL PLAN MONTHLY RATE	REGULAR VISION PLAN MONTHLY RATE	VISION PLAN PLUS MONTHLY RATE
Individual	$34.53	$4.34	$16.84
Family	$81.64	$10.30	$39.91

** Dental and vision rates are applicable to those currently enrolled. If you did not elect retiree dental coverage or COBRA vision coverage within 60 days of your retirement, you are not eligible to enroll.*