Bank Street College of Education

2026 MEDICAL PLAN BENEFIT SUMMARIES (PPO and EPO PLANS)

	PPO		EPO
Covered Medical Benefits	**In Network**	**Out-of-Network**	**In Network Only**
Annual Medical Deductible	$250/$500	$1,000/$2,000	$250/$500
Coinsurance	10%	30%	10%
Maximum Out-of-Pocket responsibility	$2,500/$5,000	$4,000/$8,000	$6,600/$13,200
Abortions			
Maximum Per Calendar Year	1 Elective Abortion	1 Elective Abortion	2 Elective Abortion
Paid by Plan	90% after deductible	70% after deductible	90% after deductible
	Medically Necessary Abortions Have No Limit	Medically Necessary Abortions Have No Limit	Medically Necessary Abortions Have No Limit
Acupuncture Treatment			
Co-pay per visit	$40	70% after deductible	$35
Ambulance Transportation			
Paid by Plan	90% after deductible (in or out-of-network)	90% after deductible (in or out-of-network)	90% after deductible (in or out-of-network)
Autism			
Autism Other Services			
Paid by Plan	90% after deductible	70% after deductible	90% after deductible
ABA therapy			
Co-pay per visit	$25	70% after deductible	$20
Cardiac Pulmonary Rehabilitation			
Co-pay per visit	$40	70% after deductible	$35
Cardiac Rehabilitation (Phase 2)			
Co-pay per visit	$40	70% after deductible	$35
Durable Medical Equipment			
Co-pay per calendar year	90% after deductible	70% after deductible	90% after deductible
Emergency Services/Treatment			
Urgent Care			
Co-pay per visit	$40	70% after deductible	$20
Walk-in Retail Health Clinics			
Co-pay per visit	$25	70% after deductible	$20
Emergency Room Only (Facility)			
Co-pay per visit	$100 (in or out-of-network)	$100 (in or out-of-network)	$50 (in or out-of-network)
(waived if admitted Within 24 Hours)	(deductible waived)	(deductible waived)	(deductible waived)
Emergency Physicians Only			
Paid by Plan	90% deductible waived (in or out-of-network)	90% deductible waived (in or out-of-network)	90% after deductible (in or out-of-network)
Extended Care Facility, Such as Skilled Nursing, Convalescent or Subacute Facility:			
Co-pay per admission	$500	70% after deductible	90% after deductible
Maximum Days Per Calendar Year	30 days	30 days	No Limit

Hearing Services: **Exams, Tests** Paid by Plan **Hearing Aids** Maximum Benefit Every 3 Years Paid by Plan **Implantable Hearing Devices** Paid by Plan	 90% after deductible 1 Hearing Aid Per Hearing Impaired Ear Including Repair and Replacement 90% after deductible 90% after deductible	 70% after deductible 1 Hearing Aid Per Hearing Impaired Ear Including Repair and Replacement 70% after deductible 70% after deductible	 90% after deductible 1 Hearing Aid Per Hearing Impaired Ear Including Repair and Replacement 90% after deductible 90% after deductible
Home Health Care Benefits Co-pay per visit Paid by Plan	 $40 100%	 70% after deductible 70%	 90% after deductible
Hospice Care Benefits: **Hospice Services** **Outpatient Services / Outpatient Physician Charges** Co-pay per visit Paid by Plan **Inpatient Services Only** Co-pay per admission Paid by Plan **Inpatient Physician Charges Services Only** Paid by Plan	 $40 100% $500 100% 90% after deductible	 70% after deductible 70% after deductible 70% after deductible	 90% after deductible 90% after deductible 90% after deductible
Bereavement Counseling: **Outpatient Services / Outpatient Physician Charges** Co-pay per visit Paid by Plan **Inpatient Services Only** Co-pay per admission Paid by Plan **Inpatient Physician Charges Services Only** Paid by Plan	 $40 100% $500 100% 90% after deductible	 70% after deductible 70% after deductible 70% after deductible	 90% after deductible 90% after deductible 90% after deductible
Hospital Services **Pre-Admission Testing** Paid by Plan **Inpatient Services Only; Room and Board Subject to the Payment of Semi-Private Room Rate or Negotiated Room Rate** Co-pay per admission	 90% after deductible $500	 70% after deductible 70% after deductible	 90% after deductible $250
Inpatient Physician Charges Services Only Paid by Plan	 90% after deductible	 70% after deductible	 90% after deductible

Outpatient Services / Outpatient Physician Charges Paid by Plan	90% after deductible	70% after deductible	90% after deductible
Outpatient Advanced Imaging Charges Paid by Plan	90% after deductible	70% after deductible	90% after deductible
Outpatient Lab and X-ray Charges Paid by Plan	90% after deductible	70% after deductible	90% after deductible
Outpatient Surgery / Surgeon Charges and Ambulatory Surgical Centers Facility Charges Only Co-pay per visit Paid by Plan	$250 100%	70% after deductible	90% after deductible
Outpatient Surgeon and Ambulatory Surgical Centers Surgeon Charges Only Paid by Plan	90% after deductible	70% after deductible	90% after deductible
Physician Clinic Visits in an Outpatient Hospital Setting - Physician Claim: Co-pay per visit - Primary Care Physician Co-pay per visit - Specialist	$25 $40	70% after deductible 70% after deductible	$20 $35
Physician Clinic Visits in an Outpatient Hospital Setting - Facility Claim: Paid by Plan	90% after deductible	70% after deductible	90% after deductible
Infertility Treatment Maximum Per Calendar Year Paid by Plan	3 Cycles of IVF 90% after deductible	3 Cycles of IVF 70% after deductible	3 Cycles of IVF 90% after deductible
Manipulations Co-pay per visit	$40	70% after deductible	$35
Mental Health, Substance Abuse Disorder and Chemical Dependency Benefits **Inpatient Services Only** Co-pay per admission	$500	70% after deductible	$250
Inpatient Physician Charges Services Only Paid by Plan	90% after deductible	70% after deductible	90% after deductible
Residential Services Only Co-pay per admission	$500	70% after deductible	$250
Residential Physician Charges Services Only Paid by Plan	90% after deductible	70% after deductible	90% after deductible
Outpatient or Partial Hospitalization Services and Physician Charges Paid by Plan	90% after deductible	70% after deductible	90% after deductible
Office Visit Co-pay per visit	$25	70% after deductible	$20
Nursery and Newborn Expenses Paid by Plan Co-pay will be waived for Newborn initial stay Days 0-5)	90% after deductible	70% after deductible	90% after deductible

Physician's Office Services			
Co-pay per visit - Primary Care Physician	$25	70% after deductible	$20
Co-pay per visit - Specialist	$40	70% after deductible	$35
Post Cochlear Aural Therapy			
Maximum Visits Per Calendar Year	30 Visits	30 Visits	90 Visits
Post Cochlear Aural Outpatient Hospital			
Co-pay per visit	$40	70% after deductible	$20 PCP / $35 Specialist
Maximum Visits Per Calendar Year	30 visits	30 visits	30 visits
Post Cochlear Aural Office Therapy			
Co-pay per visit - Primary Care Physician	$25	30 visits	$20
Co-pay per visit - Specialist	$40	70% after deductible	$35
Maximum Visits Per Calendar Year	30 visits	30 visits	30 Visits
Preventive Care / Routine Care Benefits			
Preventive Care / Routine Physical Exams at Appropriate Ages			
Paid by Plan	100%	70% after deductible	100%
Immunizations			
Paid by Plan	100%	70% after deductible	100%
Foreign Travel Immunizations			
Paid by Plan	100%	70% after deductible	100%
Preventive Care / Routine Diagnostic Tests, Lab and X-Rays at Appropriate Ages			
Paid by Plan	100%	70% after deductible	100%
Preventive / Routine Mammograms and Breast Exams			
Maximum Exams Per Calendar Year Including 3-D Mammograms for Preventive Screening	1 Exam	1 Exam	1 Exam
Paid by Plan	100%	70% after deductible	100%
3-D Mammograms for Preventive Screenings			
Included in Preventive / Routine Mammograms and Breast Exam Maximum			
Paid by Plan	100%		100%
3-D Mammograms for Diagnosis / Treatment of a Covered Medical Benefit			
Paid by Plan	100%	70% after deductible	100%
Preventive / Routine Pelvic Exams and Pap Tests			
Maximum Exams Per Calendar Year	1 exam	1 exam	1 exam
Paid by Plan	100%	70% after deductible	100%
Preventive Routine PSA Tests and Prostate Exams			
Maximum Exams Per Calendar Year	1 Exam	1 Exam	1 Exam
Paid by Plan	100%	70% after deductible	100%
Preventive Routine Screenings / Services at Appropriate Age & Gender			
Paid by Plan	100%	70% after deductible	100%
Preventive / Routine Autism Screening			
From Ages 0 to 21			
Paid by Plan	100%	70% after deductible	100%
Preventive Routine Colonoscopies, Sigmoidoscopies and Similar Routine Surgical Procedures Performed for Preventive Reasons			
Paid by Plan	100%	70% after deductible	100%

Preventive / Routine Hearing Exams Paid by Plan	100%	70% after deductible	100%
Preventive / Routine Counseling for Alcohol or Substance Abuse Disorder, Tobacco / Nicotine Use, Obesity, Diet and Nutrition Paid by Plan	100%	70% after deductible	100%
In Addition, the Following Preventive / Routine Services Are Covered for Women **Screening for Gestational Diabetes** **Papillomavirus DNA Testing*** **Counseling for Sexually Transmitted Infections (provided annually)*** **Counseling for Human Immune Deficiency Virus (provided annually)*** **Breastfeeding Support, Supplies and Counseling** **Counseling for Interpersonal and Domestic Violence for Women*** Paid by Plan *** These services may also apply to men**	100%	70% after deductible	100%
Private Duty Nursing Services Maximum Benefit Per Calendar Year Paid by Plan After Maximum is Satisfied Maximum Benefit Per Calendar Year Paid by Plan	Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered	72 Hours 90% after deductible 504 Hours 90% after deductible
Sweat Equity Reimbursement Benefits **For Subscriber** Maximum Benefit Per 6-month period **For Subscriber's Dependents (from age 13)** Maximum Benefit Per 6-month period	$200 (in or out-of-network) $100 (in or out-of-network)	$200 (in or out-of-network) $100 (in or out-of-network)	$200 (in or out-of-network) $100 (in or out-of-network)
Teladoc Services **General Medicine** Co-pay Per Occurrence	$10 (in or out-of-network)	$10 (in or out-of-network)	$10 (in or out-of-network)
Telehealth Co-pay Per Occurrence	$10	70% after deductible	$10
Temporomandibular Joint Disorder (TMJ) Benefits Paid by Plan	90% after deductible	70% after deductible	90% after deductible
Therapy Services Maximum Visits Per Calendar Year **Occupational / Physical / Speech Outpatient Hospital Therapy** Co-pay Per Visit **Occupational / Physical / Speech Outpatient Office Therapy** Co-pay per visit - Primary Care Physician Co-pay per visit - Specialist	90 Visits $40 $25 $40	90 Visits 70% after deductible 70% after deductible 70% after deductible	90 Visits $20 PCP / $35 Specialist $25 $35
Vision Care Benefits **Vision Therapy Benefits** Maximum Exams Per Calendar Year Maximum Visits Per Calendar Year Paid by Plan **Corneal Topographic Procedures** Maximum Benefit Per Calendar Year Paid by Plan	 1 Diagnostic Exam 2 Therapeutic Follow-Up Visits 90% after deductible 2 Studies Per Eye 90% after deductible	 1 Diagnostic Exam 2 Therapeutic Follow-Up Visits 70% after deductible 2 Studies Per Eye 70% after deductible	 1 Diagnostic Exam 2 Therapeutic Follow-Up Visits 90% after deductible 2 Studies Per Eye 90% after deductible

Wigs (Cranial Prostheses), Toupees, or Hairpieces Related to Cancer Treatment and Alopecia Areata			
Paid by Plan	90% deductible waived (in or out-of-network)	90% deductible waived (in or out-of-network)	90% after deductible
All Other Covered Expenses			
Paid by Plan	90% after deductible	70% after deductible	90% after deductible
Transplant Services - Designated Transplant Facility			
Transplant Services			
Paid by Plan	90% after deductible	Not Applicable	90% after deductible
Travel and Housing			
Maximum Benefit Per Treatment	$10,000	Not Applicable	$10,000
Paid by Plan	90% after deductible		90% after deductible
Prescription Drug Benefits			
Annual Pharmacy Deductible	$100	Not Applicable	$0
Participating Retail Pharmacy (30 Day Supply)			
Tier 1 (Generic & Some Brand-Name)	$15	Not Covered	$15
Tier 2 (Preferred Brand-Name & Some Generic)	$30	Not Covered	$30
Tier 3 (Non-Preferred Brand-Name & Non-Preferred Generic)	$60	Not Covered	$35
Optum Home Delivery (90 Day Supply)			
Tier 1 (Generic & Some Brand-Name)	$37.50	Not Covered	$37.50
Tier 2 (Preferred Brand-Name & Some Generic)	$75	Not Covered	$52.50
Tier 3 (Non-Preferred Brand-Name & Non-Preferred Generic)	$150	Not Covered	$52.50
Specialty Medications (30 Day Supply)			
Tier 1 (Generic & Some Brand-Name)	$15	Not Covered	$15
Tier 2 (Preferred Brand-Name & Some Generic)	$30	Not Covered	$30
Tier 3 (Non-Preferred Brand-Name & Non-Preferred Generic)	$60	Not Covered	$35