

	Empire EPO/PPO Platinum PPO 15/0%/3500 80th Percentile FAIR Health (PPO) (UCR=80th%)		Empire EPO/PPO Platinum PPO 5/0%/2600 (PPO) (UCR=140mc%)		Empire EPO/PPO Platinum PPO 250/10%/5250 (PPOc) (UCR=140mc%)		Empire EPO/PPO Gold PPO 1000/10%/5000 (PPOc) (UCR=140mc%)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	10/35/75		10/35/75		10/35/75		10/50/75	
Cost Share Information								
Individual/Family Deductible	N/A	\$2,000/\$4,000 embedded	N/A	\$2,000/\$4,000 embedded	\$250/\$500 embedded	\$2,000/\$4,000 embedded	\$1,000/\$2,000 embedded	\$2,000/\$4,000 embedded
Individual/Family OOP Limit	\$3,500/\$7,000	\$7,000/\$14,000 (incl ded)	\$2,600/\$5,200	\$5,200/\$10,400 (incl ded)	\$5,250/\$10,500 (incl ded)	\$10,500/\$21,000 (incl ded)	\$5,000/\$10,000 (incl ded)	\$10,000/\$20,000 (incl ded)
Co-Insurance	0%	30%	0%	30%	10%	30%	10%	30%
Office Visits								
Primary Care	\$15	30% after ded	\$5	30% after ded	\$10 ded waived	30% after ded	\$30 ded waived	30% after ded
Specialist	\$15	30% after ded	\$10	30% after ded	\$20 ded waived	30% after ded	\$50 ded waived	30% after ded
Inpatient Services								
Inpatient Hospital	\$300/admit	30% after ded	\$200/admit	30% after ded	10% after ded	30% after ded	10% after ded	30% after ded
Mental Health Inpatient	\$300/admit	30% after ded	\$200/admit	30% after ded	10% after ded	30% after ded	10% after ded	30% after ded
Outpatient Services								
Outpatient Facility Lab/X-Ray	\$200 Lab-No charge; X-ray: Office-No charge; OP-\$20	30% after ded 30% after ded	\$150 Lab-No charge; X-ray: Office-No charge; OP-\$20	30% after ded 30% after ded	10% after ded 10% after ded	30% after ded 30% after ded	10% after ded 10% after ded	30% after ded 30% after ded
Mental Health Outpatient	\$15	30% after ded	\$10	30% after ded	No charge	30% after ded	No charge	30% after ded
Emergency Care								
Emergency Room	\$200	Paid as in-network	\$200	Paid as in-network	\$250 ded waived	Paid as in-network	\$500 ded waived	Paid as in-network
Urgent Care	\$25	Paid as in-network	\$25	Paid as in-network	\$50 ded waived	Paid as in-network	\$75 ded waived	Paid as in-network
Single	1 x \$1,506.09		1 x \$1,379.30		1 x \$1,317.88		1 x \$1,194.33	
EE with Spouse	0 x \$3,012.18		0 x \$2,758.60		0 x \$2,635.76		0 x \$2,388.66	
EE with Child(ren)	0 x \$2,560.35		0 x \$2,344.81		0 x \$2,240.40		0 x \$2,030.36	
Family	1 x \$4,292.36		1 x \$3,931.01		1 x \$3,755.96		1 x \$3,403.84	
Monthly Cost	2 \$5,798.45		2 \$5,310.31		2 \$5,073.84		2 \$4,598.17	
Annual Cost	\$69,581.40		\$63,723.72		\$60,886.08		\$55,178.04	

	Empire EPO/PPO Platinum EPO 5/0%/2600 (EPO) (UCR=N/A)		Empire EPO/PPO Platinum EPO 15/0%/3500 (EPO) (UCR=N/A)		Empire EPO/PPO Gold PPO 1350/0%/3000 w/HSA (HSA) (UCR=140mc%)		Empire EPO/PPO Gold EPO 25/0%/6000 (EPO) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	10/35/75		10/35/75		10/50/80 IntDed		10/50/75	
Cost Share Information								
Individual/Family Deductible	N/A		N/A		\$1,350/\$2,700 non-embedded	\$2,700/\$5,400 non-embedded	N/A	
Individual/Family OOP Limit	\$2,600/\$5,200		\$3,500/\$7,000		\$3,000/\$6,000 (incl ded)	\$6,000/\$12,000 (incl ded)	\$6,000/\$12,000	
Co-Insurance	0%		0%		0%	30%	0%	
Office Visits								
Primary Care	\$5		\$15		\$15 after ded	30% after ded	\$25	
Specialist	\$10		\$15		\$30 after ded	30% after ded	\$50	
Inpatient Services								
Inpatient Hospital	\$200/admit		\$300/admit		\$400/admit after ded	30% after ded	\$400/day; 4 days max/admit	
Mental Health Inpatient	\$200/admit		\$300/admit		\$400/admit after ded	30% after ded	\$400/day; 4 days max/admit	
Outpatient Services								
Outpatient Facility	\$150		\$200		\$300 after ded	30% after ded	\$400	
Lab/X-Ray	Lab-No charge; X-ray: Office-No charge; OP-\$20		Lab-No charge; X-ray: Office-No charge; OP-\$20		Office-\$15 after ded; OP- \$300 after ded	30% after ded	Lab-No charge; X-ray: Office-No charge; OP-\$50	
Mental Health Outpatient	\$10		\$15		\$30 after ded	30% after ded	\$50	
Emergency Care								
Emergency Room	\$200		\$200		\$300 after ded	Paid as in-network	\$400	
Urgent Care	\$25		\$25		\$30 after ded	Paid as in-network	\$75	
Single	1 x \$1,183.08		1 x \$1,164.53		1 x \$1,120.65		1 x \$1,036.32	
EE with Spouse	0 x \$2,366.16		0 x \$2,329.06		0 x \$2,241.30		0 x \$2,072.64	
EE with Child(ren)	0 x \$2,011.24		0 x \$1,979.70		0 x \$1,905.11		0 x \$1,761.74	
Family	1 x \$3,371.78		1 x \$3,318.91		1 x \$3,193.85		1 x \$2,953.51	
Monthly Cost	2 \$4,554.86		2 \$4,483.44		2 \$4,314.50		2 \$3,989.83	
Annual Cost	\$54,658.32		\$53,801.28		\$51,774.00		\$47,877.96	

	Empire EPO/PPO Gold EPO 1000/10%/5000 (EPOc) (UCR=N/A)		Empire EPO/PPO Gold EPO 35/10%/5850 (EPOc) (UCR=N/A)		Empire EPO/PPO Gold EPO 1500/10%/7000 (EPOc) (UCR=N/A)		Empire EPO/PPO Gold EPO 500/20%/7350 (EPOc) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	10/50/75		10/50/75		10/50/75		10/50/75	
Cost Share Information								
Individual/Family Deductible	\$1,000/\$2,000 embedded		N/A		\$1,500/\$3,000 embedded		\$500/\$1,000 embedded	
Individual/Family OOP Limit	\$5,000/\$10,000 (incl ded)		\$5,850/\$11,700		\$7,000/\$14,000 (incl ded)		\$7,350/\$14,700 (incl ded)	
Co-Insurance	10%		10%		10%		20%	
Office Visits								
Primary Care	\$30 ded waived		\$35		\$30 ded waived		\$25 ded waived	
Specialist	\$50 ded waived		\$50		\$60 ded waived		\$50 ded waived	
Inpatient Services								
Inpatient Hospital	10% after ded		\$500/day; 4 days/admit		10% after ded		20% after ded	
Mental Health Inpatient	10% after ded		\$500/day; 4 days/admit		10% after ded		20% after ded	
Outpatient Services								
Outpatient Facility	10% after ded		\$500		10% after ded		20% after ded	
Lab/X-Ray	10% after ded		Lab-No charge; X-ray: Office-No charge; OP- \$100		10% after ded		20% after ded	
Mental Health Outpatient	No charge		\$50		No charge		No charge	
Emergency Care								
Emergency Room	\$500 ded waived		\$400		\$400 ded waived		\$400 ded waived	
Urgent Care	\$75 ded waived		\$100		\$75 ded waived		\$75 ded waived	
Single	1 x \$1,024.46		1 x \$1,024.06		1 x \$999.43		1 x \$998.72	
EE with Spouse	0 x \$2,048.92		0 x \$2,048.12		0 x \$1,998.86		0 x \$1,997.44	
EE with Child(ren)	0 x \$1,741.58		0 x \$1,740.90		0 x \$1,699.03		0 x \$1,697.82	
Family	1 x \$2,919.71		1 x \$2,918.57		1 x \$2,848.38		1 x \$2,846.35	
Monthly Cost	2 \$3,944.17		2 \$3,942.63		2 \$3,847.81		2 \$3,845.07	
Annual Cost	\$47,330.04		\$47,311.56		\$46,173.72		\$46,140.84	

	Empire EPO/PPO Silver PPO 3000/0%/5250 w/HSA (HSA) (UCR=140mc%)		Empire EPO/PPO Silver PPO 2700/30%/5000 w/HSA (HSA) (UCR=140mc%)		Empire EPO/PPO Silver EPO 2750/30%/7350 (EPOc) (UCR=N/A)		Empire EPO/PPO Silver EPO 2500/30%/7500 (EPOc) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	10/40/80 IntDed		10/50/80 IntDed		15/50/80/250 ded T2-3		15/50/80/250 ded T2-3	
Cost Share Information								
Individual/Family Deductible	\$3,000/\$6,000 embedded	\$6,000/\$12,000 embedded	\$2,700/\$5,400 non-embedded	\$5,400/\$10,800 non-embedded	\$2,750/\$5,500 embedded		\$2,500/\$5,000 embedded	
Individual/Family OOP Limit	\$5,250/\$10,500 (incl ded)	\$10,500/\$21,000 (incl ded)	\$5,000/\$10,000 (incl ded)	\$10,000/\$20,000 (incl ded)	\$7,350/\$14,700 (incl ded)		\$7,500/\$15,000 (incl ded)	
Co-Insurance	0%	30%	30%	50%	30%		30%	
Office Visits								
Primary Care	\$25 after ded	30% after ded	30% after ded	50% after ded	\$40 ded waived		\$40 ded waived	
Specialist	\$50 after ded	30% after ded	30% after ded	50% after ded	\$80 ded waived		\$70 ded waived	
Inpatient Services								
Inpatient Hospital	\$500/day after ded; 4 days/admit	30% after ded	30% after ded	50% after ded	30% after ded		30% after ded	
Mental Health Inpatient	\$500/day after ded; 4 days/admit	30% after ded	30% after ded	50% after ded	30% after ded		30% after ded	
Outpatient Services								
Outpatient Facility Lab/X-Ray	\$200 after ded Office-\$25 after ded; OP-\$200 after ded	30% after ded 30% after ded	30% after ded 30% after ded	50% after ded 50% after ded	30% after ded 30% after ded		30% after ded 30% after ded	
Mental Health Outpatient	\$50 after ded	30% after ded	30% after ded	50% after ded	No charge		No charge	
Emergency Care								
Emergency Room Urgent Care	\$300 after ded \$50 after ded	Paid as in-network Paid as in-network	30% after ded 30% after ded	Paid as in-network Paid as in-network	\$700 ded waived \$80 ded waived		\$700 after ded \$75 ded waived	
Single	1 x \$979.16		1 x \$949.67		1 x \$891.19		1 x \$877.30	
EE with Spouse	0 x \$1,958.32		0 x \$1,899.34		0 x \$1,782.38		0 x \$1,754.60	
EE with Child(ren)	0 x \$1,664.57		0 x \$1,614.44		0 x \$1,515.02		0 x \$1,491.41	
Family	1 x \$2,790.61		1 x \$2,706.56		1 x \$2,539.89		1 x \$2,500.31	
Monthly Cost	2 \$3,769.77		2 \$3,656.23		2 \$3,431.08		2 \$3,377.61	
Annual Cost	\$45,237.24		\$43,874.76		\$41,172.96		\$40,531.32	

	Empire EPO/PPO Silver EPO 1500/30%/7350 (EPOc) (UCR=N/A)		Empire EPO/PPO Silver EPO 3000/30%/7350 (EPOc) (UCR=N/A)		Empire EPO/PPO Silver EPO 3000/0%/5250 w/HSA (HSA) (UCR=N/A)		Empire EPO/PPO Silver EPO 2700/30%/5000 w/HSA (HSA) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	15/50/80/250 ded T2-3		15/50/90 IntDed T2-3		10/40/80 IntDed		10/50/80 IntDed	
Cost Share Information								
Individual/Family Deductible	\$1,500/\$3,000 embedded		\$3,000/\$6,000 embedded		\$3,000/\$6,000 embedded		\$2,700/\$5,400 non-embedded	
Individual/Family OOP Limit	\$7,350/\$14,700 (incl ded)		\$7,350/\$14,700 (incl ded)		\$5,250/\$10,500 (incl ded)		\$5,000/\$10,000 (incl ded)	
Co-Insurance	30%		30%		0%		30%	
Office Visits								
Primary Care	\$35 ded waived visits 1-3; 30% after ded visits 4+		\$30 ded waived		\$25 after ded		30% after ded	
Specialist	\$35 ded waived visits 1-3; 30% after ded visits 4+		\$60 ded waived		\$50 after ded		30% after ded	
Inpatient Services								
Inpatient Hospital	30% after ded		30% after ded		\$500/day after ded; 4 days/admit		30% after ded	
Mental Health Inpatient	30% after ded		30% after ded		\$500/day after ded; 4 days/admit		30% after ded	
Outpatient Services								
Outpatient Facility	30% after ded		30% after ded		\$200 after ded		30% after ded	
Lab/X-Ray	30% after ded		30% after ded		Office-\$25 after ded; OP-\$200 after ded		30% after ded	
Mental Health Outpatient	30% after ded		No charge		\$50 after ded		30% after ded	
Emergency Care								
Emergency Room	\$500 after ded		\$700 after ded		\$300 after ded		30% after ded	
Urgent Care	\$75 after ded		\$75 ded waived		\$50 after ded		30% after ded	
Single	1 x \$868.89		1 x \$850.75		1 x \$841.32		1 x \$815.17	
EE with Spouse	0 x \$1,737.78		0 x \$1,701.50		0 x \$1,682.64		0 x \$1,630.34	
EE with Child(ren)	0 x \$1,477.11		0 x \$1,446.28		0 x \$1,430.24		0 x \$1,385.79	
Family	1 x \$2,476.34		1 x \$2,424.64		1 x \$2,397.76		1 x \$2,323.23	
Monthly Cost	2 \$3,345.23		2 \$3,275.39		2 \$3,239.08		2 \$3,138.40	
Annual Cost	\$40,142.76		\$39,304.68		\$38,868.96		\$37,660.80	

Prepared For: **Empire 2019 4th qtr EPO PPO New York City**

New York County, NY 10001

Prepared By: Clifford Grekin Inc. - (631)963-6020

Health Plan Comparison Report (4L)

Effective Date: 10/01/2019

Prepared On: 07/15/2019

Report ID: 36624063

SIC: 0000

	Empire EPO/PPO Bronze EPO 5500/20%/6700 w/HSA (HSA) (UCR=N/A)		Empire EPO/PPO Bronze EPO 5500/35%/6700 w/HSA (HSA) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs				
Drug Card	15/50/90 IntDed		15/50/90 IntDed	
Cost Share Information				
Individual/Family Deductible	\$5,500/\$11,000 non-embedded		\$5,500/\$11,000 non-embedded	
Individual/Family OOP Limit	\$6,700/\$13,400 (incl ded)		\$6,700/\$13,400 (incl ded)	
Co-Insurance	20%		35%	
Office Visits				
Primary Care	\$50 after ded		35% after ded	
Specialist	\$75 after ded		35% after ded	
Inpatient Services				
Inpatient Hospital	\$500/day after ded; 4 days/admit		35% after ded	
Mental Health Inpatient	\$500/day after ded; 4 days/admit		35% after ded	
Outpatient Services				
Outpatient Facility	\$350 after ded		35% after ded	
Lab/X-Ray	Office-\$50 after ded; OP- \$350 after ded		35% after ded	
Mental Health Outpatient	\$75 after ded		35% after ded	
Emergency Care				
Emergency Room	\$350 after ded		35% after ded	
Urgent Care	\$75 after ded		35% after ded	
Single	1 x \$703.69		1 x \$701.86	
EE with Spouse	0 x \$1,407.38		0 x \$1,403.72	
EE with Child(ren)	0 x \$1,196.27		0 x \$1,193.16	
Family	1 x \$2,005.52		1 x \$2,000.30	
Monthly Cost	2 \$2,709.21		2 \$2,702.16	
Annual Cost	\$32,510.52		\$32,425.92	