

	Empire EPO/PPO Platinum PPO 15%/3500 80th Percentile FAIR Health (PPO) (UCR=80fh%)		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 \$1,478.55		1 x \$1,354.07		1 x \$1,293.78		1 x \$1,172.49	
EE with Spouse	0 x \$2,957.10		0 x \$2,708.14		0 x \$2,587.56		0 x \$2,344.98	
EE with Child(ren)	0 x \$2,513.54		0 x \$2,301.92		0 x \$2,199.43		0 x \$1,993.23	
Family	1 x \$4,213.87		1 x \$3,859.10		1 x \$3,687.27		1 x \$3,341.60	
Monthly Cost	2 \$5,692.42		2 \$5,213.17		2 \$4,981.05		2 \$4,514.09	
Annual Cost	\$68,309.04		\$62,558.04		\$59,772.60		\$54,169.08	

	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 \$1,161.44		1 x \$1,143.24		1 x \$1,100.15		1 x \$1,017.37	
EE with Spouse	0 x \$2,322.88		0 x \$2,286.48		0 x \$2,200.30		0 x \$2,034.74	
EE with Child(ren)	0 x \$1,974.45		0 x \$1,943.51		0 x \$1,870.26		0 x \$1,729.53	
Family	1 x \$3,310.10		1 x \$3,258.23		1 x \$3,135.43		1 x \$2,899.50	
Monthly Cost	2 \$4,471.54		2 \$4,401.47		2 \$4,235.58		2 \$3,916.87	
Annual Cost	\$53,658.48		\$52,817.64		\$50,826.96		\$47,002.44	

	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 \$1,005.73		1 x \$1,005.33		1 x \$981.15		1 x \$980.46	
EE with Spouse	0 x \$2,011.46		0 x \$2,010.66		0 x \$1,962.30		0 x \$1,960.92	
EE with Child(ren)	0 x \$1,709.74		0 x \$1,709.06		0 x \$1,667.96		0 x \$1,666.78	
Family	1 x \$2,866.33		1 x \$2,865.19		1 x \$2,796.28		1 x \$2,794.31	
Monthly Cost	2 \$3,872.06		2 \$3,870.52		2 \$3,777.43		2 \$3,774.77	
Annual Cost	\$46,464.72		\$46,446.24		\$45,329.16		\$45,297.24	

	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 \$961.25		1 x \$932.30		1 x \$874.89		1 x \$861.26	
EE with Spouse	0 x \$1,922.50		0 x \$1,864.60		0 x \$1,749.78		0 x \$1,722.52	
EE with Child(ren)	0 x \$1,634.13		0 x \$1,584.91		0 x \$1,487.31		0 x \$1,464.14	
Family	1 x \$2,739.56		1 x \$2,657.06		1 x \$2,493.44		1 x \$2,454.59	
Monthly Cost	2 \$3,700.81		2 \$3,589.36		2 \$3,368.33		2 \$3,315.85	
Annual Cost	\$44,409.72		\$43,072.32		\$40,419.96		\$39,790.20	

	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 \$853.00		1 x \$835.19		1 x \$825.94		1 x \$800.27	
EE with Spouse	0 x \$1,706.00		0 x \$1,670.38		0 x \$1,651.88		0 x \$1,600.54	
EE with Child(ren)	0 x \$1,450.10		0 x \$1,419.82		0 x \$1,404.10		0 x \$1,360.46	
Family	1 x \$2,431.05		1 x \$2,380.29		1 x \$2,353.93		1 x \$2,280.77	
Monthly Cost	2 \$3,284.05		2 \$3,215.48		2 \$3,179.87		2 \$3,081.04	
Annual Cost	\$39,408.60		\$38,585.76		\$38,158.44		\$36,972.48	

Prepared For: **Empire 2019 4th qtr EPO PPO Nassau Suffolk**

Nassau County, NY 11565

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: 36624072

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 \$690.82		1 x \$689.03	
EE with Spouse	0 x \$1,381.64		0 x \$1,378.06	
EE with Child(ren)	0 x \$1,174.39		0 x \$1,171.35	
Family	1 x \$1,968.84		1 x \$1,963.74	
Monthly Cost	2 \$2,659.66		2 \$2,652.77	
Annual Cost	\$31,915.92		\$31,833.24	

The rates and benefits in this report are for discussion and estimation purposes only and are not valid without approval from the insurance carriers. Final rates must be based on insurance carrier confirmation and final enrollment. Rx Legend: Generic/Preferred Brand/Non-Preferred Brand/Specialty/Deductible