	Current (As Administered Today)		NYCE PPO		
	CBP Plan (Empire/Emblem)				
	In-Network	Out-Of-Network	In-Network Preferred (H&H, ACPNY)	In-Network Standard	Out-Of-Network*
Preferred Providers	MSK, HSS, ACPNY	None	H&H added	None	None
Deductible - Single	$0 Individual	$200 Individual	$0 Individual	$0 Individual	$200 Individual
Deductible - Family	$0 Family	$500 Family	$0 Family	$0 Family	$500 Family
Out of Pocket Max - Single	$4,550 (prof) + $2,600 (facility) = $7,150	No limit	$7,150 Individual (combined Pref / Non-Pref)		No limit
Out of Pocket Max - Family	$9,100 (prof) + $5,200 (facility) = $14,300	No limit	$14,300 Family (combined Pref / Non-Pref)		No limit
Professional Services					
Preventative Services	$0	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0	$0	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Routine Pediatric Eye Exam	$15	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0, H&H added	$15	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Routine Hearing Screening	$15	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0, H&H added	$15	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Primary Care Office Visits	$0 ACP, $15 otherwise	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0, H&H added	$15	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Specialist Visit	$30 ($0 ACP)	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0, H&H added	$30	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Centers of Excellence	$0 (MSK, HSS), does not apply to physician fees	NA	$0 (MSK, HSS), does not apply to physician fees	NA	NA
Telemedicine Direct w/Docs	$0 ACP, $15 PCP, $30 Spec	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0, H&H added	$15 PCP/$30 Specialist	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Allergy testing	$20 per visit, two copay limit w/lab, x-ray, and office visit from same provider on same day	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0, H&H added	$20 per visit, two copay limit w/lab, x-ray, and office visit from same provider on same day	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Teladoc	$10	NA	NA	$10	NA
Walk-In Clinics	$0 ACP, $15 for PCP, $30 for Specialist	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0, H&H added	$15 for PCP, $30 for Specialist	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Prenatal Care	$0	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0	$0	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee

*Provider Payment at 100% of Medicare

Balance-billing may also apply to all out-of-network services (current and NYCE PPO)

	Current (As Administered Today)		NYCE PPO		
	CBP Plan (Empire/Emblem)				
	In-Network	Out-Of-Network	In-Network Preferred (H&H, ACPNY)	In-Network Standard	Out-Of-Network*
Inpatient Services					
Facility	$300 per stay max $750/year	$500 per stay max $1,250/year; 20% coinsurance w/$2,000 max	$0, H&H added	$300 per stay (max $750 per year)	$500 per stay max $1,250/year; 20% coinsurance w/$2,000 max
Professional/Surgeon	$0	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0	$0	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Skilled Nursing	$300 per stay max $750/year (Limit 90 days/yr)	$500 per stay max $1,250/year; 20% coinsurance w/$2,000 max	N/A	$300 per stay max $750/year (Limit 90 days/yr)	$500 per stay max $1,250/year; 20% coinsurance w/$2,000 max
Hospice	$0, 210 day lifetime max	$0, 210 day lifetime max	$0, limit removed	$0, limit removed	$0, limit removed
Private Duty Nursing	$0	$250 Deductible, 20% coinsurance	$0	$0	Deductible, 20% coinsurance
Outpatient Services					
Outpatient Surgery - Facility	20% (up to $200 per person per calendar year)	$500 Copay per person per visit and 20% coinsurance and balance billing	$0, H&H added	20% (up to $200 per person per calendar year)	$500 Copay per person per visit and 20% coinsurance and balance billing
Outpatient Surgery - Professional	$0	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0	$0	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Diagnostic X-Ray	$20 per visit, two copay limit w/lab, x-ray, and office visit from same provider on same day	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0, H&H added	$20 per visit, two copay limit w/lab, x-ray, and office visit from same provider on same day	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Diagnostic Laboratory	$20 per visit, two copay limit w/lab, x-ray, and office visit from same provider on same day	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0, H&H added	$20 per visit, two copay limit w/lab, x-ray, and office visit from same provider on same day	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Diagnostic Complex Imaging	$50 Preferred, $100 Non-preferred	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$25, H&H	$50 Preferred, $100 Non-preferred	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Chemotherapy	$0 in PCP or Specialist Office, 20% (up to $200 per year) in Outpatient Hospital Facility	$500 copayment per visit ($1,250 max), 20% coinsurance and balance billing	$0, H&H added	$0 in PCP or Specialist Office, 20% (up to $200 per year) in Outpatient Hospital Facility	$500 copayment per visit ($1,250 max), 20% coinsurance and balance billing
Cardiac Rehab	$0	$500 copayment per visit ($1,250 max), 20% coinsurance and balance billing	$0, includes Emblem Cardiac Rehab network in the NY downstate 13 counties	$30 if outside of the NY downstate 13 counties	$500 copayment per visit ($1,250 max), 20% coinsurance and balance billing
PT/OT/ST	PT: $20 per office visit ST: $0 at ACPNY, $15 if at PCP, $30 if at Specialist office OT: Available as part of Home Health visit; or through Skilled Nursing Facilities	PT/ST: After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee OT: See OON description for home health visit or skilled nursing facilities	$0, H&H added	PT: $20 per office visit ST: $15 if at PCP, $30 if at Specialist office OT: Available as part of Home Health visit; or through Skilled Nursing Facilities (SNF)	PT/ST: After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee OT: See OON description for Home Health Visit or Skilled Nursing Facilities

*Provider Payment at 100% of Medicare

Balance-billing may also apply to all out-of-network services (current and NYCE PPO)

	Current (As Administered Today)		NYCE PPO		
	CBP Plan (Empire/Emblem)				
	In-Network	Out-Of-Network	In-Network Preferred (H&H, ACPNY)	In-Network Standard	Out-Of-Network*
Dialysis	20% (up to $200 per person per calendar year)	20% Coinsurance, up to a maximum of $200 per person per calendar year.	$0 H&H	20% (up to $200 per person per calendar year)	20% Coinsurance, up to a maximum of $200 per person per calendar year. Up to 10 visits annually
Medications in OP or Office	$0	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0	$0	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Chiropractor	$15	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0	$15	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Outpatient Behavioral Health/Substance Use Disorder	$0 Preferred, $15 Non-preferred	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$0	$15	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Urgent Care Provider	$50 Preferred, $100 Non-Preferred	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	$25 H&H, $50 ACPNY	$50 Preferred $100 Non-preferred	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee
Emergency Room	$150; waived if admitted within 24 hours		$150; waived if admitted within 24 hours		
Ambulance (emergency only)	$0	$0	$0	$0	$0
Home Health Care	$0 (max 200 visits)	$50 per episode, 20% coinsurance, max 40 visits	$0 (max 200 visits)		$50 per episode, 20% coinsurance, max 40 visits
Durable Medical Equipment	$100 deductible, combined w/Orthotic Braces and Prosthetics	$100 deductible, combined w/Orthotic Braces and Prosthetics, 50% of U&C	NA	$100 deductible, combined w/Orthotic Braces and Prosthetics	$100 deductible, combined w/Orthotic Braces and Prosthetics, balance billing after provider payment at 100% of medicare
Orthotic Braces	$100 deductible, combined w/DME and Prosthetics	$100 deductible, combined w/DME and Prosthetics, 50% of U&C	NA	$100 deductible, combined w/DME and Prosthetics	$100 deductible, combined w/DME and Prosthetics, balance biling after provider payment at 100% of medicare
Prosthetics	$100 deductible, combined w/Orthotic Braces and DME	$100 deductible, combined w/Orthotic Braces and DME, 50% of U&C	NA	$100 deductible, combined w/Orthotic Braces and DME	$100 deductible, combined w/DME and Orthotic Braces, balance billing after provider payment at 100% of medicare

*Provider Payment at 100% of Medicare

Balance-billing may also apply to all out-of-network services (current and NYCE PPO)

Preventive Rx Through the Affordable Care Act and NY State Diabetes Mandates	Current (As Administered Today)		NYCE PPO	
	CBP Plan (Empire/Emblem)		NYCE PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive / Diabetes	Retail: $0 insulin; $5-$15 supplies Mail Order: $12.50-$37.50 supplies	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee	Retail: $0 insulin; $5-$15 supplies Mail Order: $12.50-$37.50 supplies	After Plan deductible is met, You pay the difference between the Plan allowance and the Provider's fee

Optional Rx Rider	Current (As Administered Today) CBP Plan (Empire/Emblem)		NYCE PPO NYCE PPO	
	Retail	Mail Order	Retail	Mail Order
Generic Drugs	Retail - 30 day supply - 2 fills; 20% coninsurance with min. charge of $5 or actual cost, if less	Mandatory Mail Order - 90 day supply; $12.50 copay. Prescriptions will not be filled at retail after 2 fills. The 90 day supply can be obtained through Express Scripts or participating Duane Reade or Walgreens	Retail - 30 day supply - 2 fills; 20% coninsurance with min. charge of $5 or actual cost, if less	Mandatory Mail Order - 90 day supply; $12.50 copay. Prescriptions will not be filled at retail after 2 fills. The 90 day supply can be obtained through pharmacy(ies) selected by Plan Sponsor
Preferred Brand Drugs	Retail - 30 day supply - 2 fills; 40% coninsurance with min. charge of $25 or actual cost, if less	Mandatory Mail Order - 90 day supply; $50.00 copay. Prescriptions will not be filled at retail after 2 fills. The 90 day supply can be obtained through Express Scripts or participating Duane Reade or Walgreens	Retail - 30 day supply - 2 fills; 40% coninsurance with min. charge of $25 or actual cost, if less	Mandatory Mail Order - 90 day supply; $50.00 copay. Prescriptions will not be filled at retail after 2 fills. The 90 day supply can be obtained through pharmacy(ies) selected by Plan Sponsor
Non-Preferred Brand Drugs	Retail - 30 day supply - 2 fills; 50% coninsurance with min. charge of $40 or actual cost, if less	Mandatory Mail Order - 90 day supply; $75.00 copay. Prescriptions will not be filled at retail after 2 fills. The 90 day supply can be obtained through Express Scripts or participating Duane Reade or Walgreens	Retail - 30 day supply - 2 fills; 50% coninsurance with min. charge of $40 or actual cost, if less	Mandatory Mail Order - 90 day supply; $75.00 copay. Prescriptions will not be filled at retail after 2 fills. The 90 day supply can be obtained through pharmacy(ies) selected by Plan Sponsor
Specialty Drugs*	Covered (cost based on above categories)	Must be dispensed by the Specialty Pharmacy Program Provider. Pre-certification required contact NYC Healthline at 1-800-521-9574	Covered (cost based on above categories)	Must be dispensed by the Specialty Pharmacy Program Provider. Pre-certification required contact Prime Therapeutics at 1-800-XXX-XXXX

* Must be dispensed by a Specialty Pharmacy