Compare our existing plan to the New York City Employees PPO (NYCE PPO) Plan.
Both the current GHI CBP plan and the NYCE PPO plan must follow all Federal and New York State mandates regarding health benefit coverage.

	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

* PICA program will remain with ESI. Contact the union if you have questions about your prescription benefit.

† Must be dispensed by a Specialty Pharmacy