Prepared For: Empire 2017 4th qtr EPO PPO

Albany County, NY 12007

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

Health Plan Comparison Report (4L)

Effective Date: 10/01/2017

Prepared On: 08/02/2017

SIC: 0000

Report ID: 33264171

In-Network Prescription Drugs Drug Card 10/35/75 Cost Share Information Individual/Family Deductible N/A	um EPO 15/0%/3000	In-Network 10/35/75 \$1,000/\$3,000 embedded	00/10%/5000 Out-Network	In-Network	/20%/7150 Out-Network	Gold EPO 150 In-Network 10/35/75	00/0%/7000 Out-Network
Prescription Drugs Drug Card 10/35/75 Cost Share Information Individual/Family Deductible N/A	k Out-Network	10/35/75	Out-Network		Out-Network		Out-Network
Prescription Drugs Drug Card 10/35/75 Cost Share Information Individual/Family Deductible N/A	k Out-Network	10/35/75	Out-Network		Out-Network		Out-Network
Prescription Drugs Drug Card 10/35/75 Cost Share Information Individual/Family Deductible N/A	k Out-Network	10/35/75	Out-Network		Out-Network		Out-Network
Drug Card 10/35/75 Cost Share Information Individual/Family Deductible N/A				10/35/75		10/35/75	
Cost Share Information Individual/Family Deductible N/A				1.57.56.7.5		10.00.70	
Individual/Family Deductible N/A		\$1,000/\$3,000 embedded					
Individual/Family Deductible N/A		\$1,000/\$3,000 embedded					
		ψ1,000/ψ0,000 embedded		\$500/\$1,500 embedded		\$1,500/\$3,000 embedded	
				\$500/\$1,500 embedded		\$1,000/\$0,000 embedded	
Individual/Family OOP Limit \$3,000/\$6,000		\$5,000/\$10,000 (incl ded)		\$7,150/\$14,300 (incl ded)		\$7,000/\$14,000 (incl ded)	
Co-Insurance 0%		10%		20%		0%	
Office Visits							
Primary Care \$15		\$30 ded waived		\$25 ded waived		\$30 ded waived	
Specialist \$30		\$50 ded waived		\$50 ded waived		\$60 after ded	
Inpatient Services							
Inpatient Hospital \$300/day up to 3 c	lays	10% after ded		20% after ded		\$500/admit after ded	
Mental Health Inpatient \$300/day up to 3 c	lays	10% after ded		20% after ded		\$500/admit after ded	
Outpatient Services							
Outpatient Facility \$200		10% after ded		20% after ded		0% after ded	
Lab/X-Ray Office-\$30 + 10%;	OP-	10% after ded		20% after ded		0% after ded	
\$200							
Mental Health Outpatient \$30		\$50 ded waived		\$50 ded waived		\$30 after ded	
Emergency Care							
Emergency Room \$200		\$300 ded waived		\$300 ded waived		\$300 after ded	
Single 1 x	8852.89	1 x \$736.20		1 x \$723.48		1 x \$714.55	
1	,705.78	0 x \$1,472.40		0 x \$1,446.96		0 x \$1,429.10	
EE with Child(ren) 0 x \$1	,449.91	0 x \$1,251.54		0 x \$1,229.92		0 x \$1,214.74	
Family 1 x \$2	,430.74	1 x \$2,098.17		1 x \$2,061.92		1 x \$2,036.47	
Monthly Cost 2 \$3	,283.63	2 \$2,834.37		2 \$2,785.40		2 \$2,751.02	
-	,403.56	\$34,012.44		\$33,424.80		\$33,012.24	
,	, 100.00	ψ54,012.44		ψ35,727.00		Ψ55,012.24	

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	Empire Blue Cross Gold EPO 2500/0%/5000 w/HRA		Empire Blu Silver EPO 150		Empire Blue Cross Silver EPO 4000/0%/7000	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs						
Drug Card	15/50/90 IntDed		15/40/80/250 ded T2-3		15/50/90 IntDed T3	
Cost Share Information						
ndividual/Family Deductible	\$2,500/\$5,000 embedded		\$1,500/\$3,000 embedded		\$4,000/\$8,000 embedded	
ndividual/Family OOP Limit	\$5,000/\$10,000 (incl ded)		\$6,500/\$13,000 (incl ded)		\$7,000/\$14,000 (incl ded)	
Co-Insurance	0%		30%		0%	
Office Visits						
Primary Care	\$25 after ded		\$35 ded waived visits 1-3; 30% after ded visits 4+		\$30 ded waived	
Specialist	\$50 after ded		\$35 ded waived visits 1-3; 30% after ded visits 4+		\$50 after ded	
Inpatient Services						
npatient Hospital	\$300/admit after ded		30% after ded		\$500/admit after ded	
Mental Health Inpatient	\$300/admit after ded		30% after ded		\$500/admit 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		0% after ded 0% after ded	
Mental Health Outpatient	\$50 after ded		\$35 ded waived visits 1-3; 30% after ded visits 4+		\$30 after ded	
Emergency Care						
Emergency Room	\$250 after ded		\$300 after ded		\$300 after ded	
Single	1 x \$645.49		1 x \$634.55		1 x \$599.20	
EE with Spouse	0 x \$1,290.98		0 x \$1,269.10		0 x \$1,198.40	
EE with Child(ren)	0 x \$1,097.33		0 x \$1,078.74		0 x \$1,018.64	
Family	1 x \$1,839.65		1 x \$1,808.47		1 x \$1,707.72	
Monthly Cost	2 \$2,485.14		2 \$2,443.02		2 \$2,306.92	
Annual Cost	\$29,821.68		\$29,316.24		\$27,683.04	