New York County, NY 10001

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

Health Plan Comparison Report (4L)

Effective Date: 01/01/2017

Report ID: 31666766

Prepared On: 10/17/2016

SIC: 0000

	Empire Blue Cross Blue Shield Gold Blue Priority EPO 35/10%/7000		Empire Blue Cross Blue Shield Gold Blue Priority EPO 1250/20%/4000		Empire Blue Cross Blue Shield Gold Blue Priority EPO 1350/0%/3000 w/HSA		Empire Blue Cross Blue Shield Silver Blue Priority EPO 1500/30%/6500	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs								
Drug Card	10/35/70		10/35/70		10/40/80 IntDed		15/40/80/250 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		\$1,250/\$2,500 embedded		\$1,350/\$2,700 non-embedded		\$1,500/\$3,000 embedded	
Individual/Family OOP Limit	\$7,000/\$14,000		\$4,000/\$8,000 (incl ded)		\$3,000/\$6,000 (incl ded)		\$6,500/\$13,000 (incl ded)	
Co-Insurance	10%		20%		0%		30%	
Office Visits								
Primary Care	\$35		\$25 ded waived		\$20 after ded		\$35 ded waived visits 1-3; 30% after ded visits 4+	
Specialist	\$50		\$50 ded waived		\$40 after ded		\$35 ded waived visits 1-3; 30% after ded visits 4+	
Inpatient Services								
Inpatient Hospital	\$500/day up to 3 days		20% after ded		\$500/admit after ded		30% after ded	
Mental Health Inpatient	\$500/day up to 3 days		20% after ded		\$500/admit after ded		30% after ded	
Outpatient Services								
Outpatient Facility Lab/X-Ray	\$500 Office-\$50 + 10%; OP- \$500 + 10%		20% after ded 20% after ded		\$200 after ded Office-\$20 after ded; OP- \$200 after ded		30% after ded 30% after ded	
Mental Health Outpatient	\$50		\$50 ded waived		\$40 after ded		\$35 ded waived visits 1-3; 30% after ded visits 4+	
Emergency Care								
Emergency Room	\$350		\$250 ded waived		\$250 after ded		\$300 after ded	
Single	1 x \$752.92		1 x \$749.94		1 x \$723.04		1 x \$645.24	
EE with Spouse	0 x \$1,505.84		0 x \$1,499.88		0 x \$1,446.08		0 x \$1,290.48	
EE with Child(ren)	0 x \$1,279.96		0 x \$1,274.90		0 x \$1,229.17		0 x \$1,096.91	
Family	1 x \$2,145.82		1 x \$2,137.33		1 x \$2,060.66		1 x \$1,838.93	
Monthly Cost	2 \$2,898.74		2 \$2,887.27		2 \$2,783.70		2 \$2,484.17	
Annual Cost	\$34,784.88		\$34,647.24		\$33,404.40		\$29,810.04	

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

Prepared For: Em	oire 2017 1st	qtr Blue Priority
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	Empire Blue Cros	s Blue Shield	Empire Blue Cros	ss Blue Shield	Empire Blue Cross Blue Shield Bronze Blue Priority EPO 5300/50%/6550 w/HSA		
	Silver Blue Priority EF w/HS		Bronze Blue Priority Ef w/HS				
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network	
Prescription Drugs							
Drug Card	10/40/80 IntDed		15/50/90 IntDed		50%/50%/50% IntDed		
Cost Share Information							
Individual/Family Deductible	\$2,700/\$5,400 embedded		\$5,500/\$11,000 embedded		\$5,300/\$10,600 embedded		
Individual/Family OOP Limit	\$4,500/\$9,000 (incl ded)		\$6,550/\$13,100 (incl ded)		\$6,550/\$13,100 (incl ded)		
Co-Insurance	0%		20%		50%		
Office Visits							
Primary Care	\$25 after ded		\$50 after ded		50% after ded		
Specialist	\$50 after ded		\$75 after ded		50% after ded		
Inpatient Services							
Inpatient Hospital	\$500/admit after ded		\$500/admit after ded		50% after ded		
Mental Health Inpatient	\$500/admit after ded		\$500/admit after ded		50% after ded		
Outpatient Services							
Outpatient Facility Lab/X-Ray	\$200 after ded Office-\$25 after ded; OP- \$200 after ded		\$350 after ded Office-\$50 after ded; OP- \$350 after ded		50% after ded 50% after ded		
Mental Health Outpatient	\$50 after ded		\$75 after ded		50% after ded		
Emergency Care							
Emergency Room	\$300 after ded		\$350 after ded		50% after ded		
Single	1 x \$628.86		1 x \$532.85		1 x \$529.95		
EE with Spouse	0 x \$1,257.72		0 x \$1,065.70		0 x \$1,059.90		
EE with Child(ren)	0 x \$1,069.06		0 x \$905.85		0 x \$900.92		
Family	1 x \$1,792.25		1 x \$1,518.62		1 x \$1,510.36		
Monthly Cost	2 \$2,421.11		2 \$2,051.47		2 \$2,040.31		
Annual Cost	\$29,053.32		\$24,617.64		\$24,483.72		
	φ20,000.02		φ24,017.04		ψ24,403.72		

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