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2018 SMALL GROUP HEALTH INSURANCE RATES

1Q - NYC - For New Groups Starting First Quarter 2018

	Aetna Gold EPO 1000 90% ID: 14038844* (EPOc) (UCR=N/A)	EmblemHealth EmblemHealth Gold 40/60* (HMOc) (UCR=N/A)	Empire Blue Priority Gold Blue Priority EPO 35/10%/5850* (EPOc) (UCR=N/A)	Empire EPO/PPO Gold EPO 35/10%/5850* (EPOc) (UCR=N/A)	HealthFirst Gold Pro EPO* (EPOc) (UCR=N/A)	Oscar Classic Gold 0 * (EPO) (UCR=N/A)	Oxford Freedom F Gold EPO 15/35 Non-Gated OHI CNT* (EPOc) (UCR=N/A)	Oxford Liberty L Gold EPO 30/60 Gated OHI CNT* (EPOc) (UCR=N/A)
Prescription Drugs Drug Card	15/65/50%/TCS/100 ded T2-4	15/35/75/100 ded	10/35/75	10/35/75	10/50/85	10/50/100	15/35/75/100 ded T2-3	15/35/75/100 ded T2-3
In-Network								
Ind/Fam Deductible Ind/Fam OOP Limit Co-Insurance Primary Care Specialist Inpatient Hospital	\$1,000/\$2,000 embedded \$6,000/\$12,000 (incl ded) 10% \$30 ded waived \$60 ded waived 10% after ded	\$250/\$500 \$5,500/\$11,000 (incl ded) 0% \$40 after ded \$60 after ded \$1,500/admit after ded; pre-auth req	N/A \$5,850/\$11,700 10% \$35 \$50 \$500/day; 4 days/admit	N/A \$5,850/\$11,700 10% \$35 \$50 \$500/day; 4 days/admit	N/A \$5,000/\$10,000 (incl ded) 0% \$25 \$40 \$500/day; \$1,500 max/admit	N/A \$5,000/\$10,000 (incl ded) 0% \$25 \$50 \$500/admit	\$1,000/\$2,000 \$4,000/\$8,000 (incl ded) 10% \$15 ded waived \$35 ded waived 10% after ded	\$1,000/\$2,000 \$4,000/\$8,000 (incl ded) 0% \$30 ded waived \$60 ded waived \$500/day after ded; \$2,000 max/admit
Out-Network								
Ind/Fam Deductible Ind/Fam OOP Limit Co-Insurance Primary Care Specialist Inpatient Hospital								
Single EE with Spouse EE with Child(ren) Family Monthly Cost Annual Cost	0 x \$878.29 0 x \$1,756.57 0 x \$1,493.09 0 x \$2,503.12 0 \$0.00 \$0.00	0 x \$739.28 0 x \$1,478.56 0 x \$1,256.78 0 x \$2,106.95 0 \$0.00 \$0.00	0 x \$836.14 0 x \$1,672.28 0 x \$1,421.44 0 x \$2,383.00 0 \$0.00 \$0.00	0 x \$891.04 0 x \$1,782.08 0 x \$1,514.77 0 x \$2,539.46 0 \$0.00 \$0.00	0 x \$717.27 0 x \$1,434.54 0 x \$1,219.36 0 x \$2,044.22 0 \$0.00 \$0.00	0 x \$717.16 0 x \$1,434.31 0 x \$1,219.16 0 x \$2,043.89 0 \$0.00 \$0.00	0 x \$881.86 0 x \$1,763.71 0 x \$1,499.16 0 x \$2,513.29 0 \$0.00 \$0.00	0 x \$824.07 0 x \$1,648.13 0 x \$1,400.91 0 x \$2,348.59 0 \$0.00 \$0.00



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	Oxford Metro M Silver EPO 30/60 Gated OHI CNT* (EPC (UCR=N/A)	0 Oc)
Prescription Drugs	10/65/50%to\$800	
Drug Card	10/65/50%05800	
In-Network		
nd/Fam Deductible nd/Fam OOP Limit Co-Insurance Primary Care Specialist npatient Hospital	\$3,000/\$6,000 \$7,150/\$14,300 (incl dec 30% \$30 ded waived \$60 ded waived 30% after ded	d)
Out-Network		
nd/Fam Deductible nd/Fam OOP Limit Co-Insurance Primary Care Specialist npatient Hospital		
Single EE with Spouse EE with Child(ren) Family Monthly Cost	0 x \$587 0 x \$1,175 0 x \$998 0 x \$1,674 0 \$0	5.15 8.88



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2018 SMALL GROUP HEALTH INSURANCE RATES

1Q - NYC - For New Groups Starting First Quarter 2018

	Aetna Gold EPO 1000 90% ID: (UCR=1	14038844* (EPOc)	Emblem EmblemHealth Gold 40/		Empire Blu Gold Blue Priority EPO (UCR	35/10%/5850* (EPOc)
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs						
rug Card	15/65/50%/TCS/100 ded T2-4		15/35/75/100 ded		10/35/75	
ost Share Information						
ndividual/Family Deductible	\$1,000/\$2,000 embedded		\$250/\$500		N/A	
ndividual/Family OOP Limit	\$6,000/\$12,000 (incl ded)		\$5,500/\$11,000 (incl ded)		\$5,850/\$11,700	
o-Insurance	10%		0%		10%	
Office Visits	i Lie					
rimary Care	\$30 ded waived		\$40 after ded		\$35	
pecialist	\$60 ded waived		\$60 after ded		\$50	
laternity Prenatal/Postnatal Care	Pre-No charge; Post-refer to carrier		No charge		No charge	
hiropractic Care	\$60 ded waived		\$60 after ded		\$50	
npatient Services						
npatient Hospital	10% after ded		\$1,500/admit after ded; pre-auth req		\$500/day; 4 days/admit	
lental Health Inpatient	10% after ded		\$1,500/admit after ded; pre-auth req		\$500/day; 4 days/admit	
ubstance Abuse Inpatient	10% after ded		\$1,500/admit after ded; pre-auth req		\$500/day; 4 days/admit	
Nutrial Condition						
Outpatient Services						
outpatient Facility	Refer to Outpatient Surgery		\$150 after ded; pre-auth req		\$500	
ab/X-Ray	10% after ded		\$60 after ded		Lab-No charge; X-ray: Office-No charge; OP- \$100	
dvanced Radiology	10% after ded		\$60 after ded		Office-\$50; OP-\$200	
lental Health Outpatient ubstance Abuse Outpatient	\$60 ded waived \$60 ded waived		\$40 after ded \$40 after ded		\$50 \$50	
mergency Care						
mergency Room	\$750 (waived if admitted) ded waived		\$200 (waived if admitted) after ded		\$350	
mbulance	10% after ded		\$100 after ded		\$350	
Irgent Care	\$75 ded waived		\$60 ded waived		\$100	
Recovery/Special Needs						
lome Health Care	25% ded waived; 40 visits/cal yr		\$40 after ded; 40 visits/plan yr; pre-auth req		\$50; 40 visits/yr	
killed Nursing	10% after ded		\$1,500/admit after ded; 200 days/plan yr; pre-auth req		\$500/day; 4 days/admit; 200 days/yr	
urable Medical Equipment	50% after ded		10% after ded; pre-auth		10%	
Single	0 x \$878.29		0 x \$739.28		0 x \$836.14	
E with Spouse	0 x \$1,756.57		0 x \$1,478.56		0 x \$1,672.28	
E with Child(ren)	0 x \$1,493.09		0 x \$1,256.78		0 x \$1,421.44	
amily	0 x \$2,503.12		0 x \$2,106.95		0 x \$2,383.00	
			,	5	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Nonthly Cost	0 \$0.00		0 \$0.00	í -	0 \$0.00	1
Annual Cost	\$0.00		\$0.00		\$0.00	
	13.00					



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2018 SMALL GROUP HEALTH INSURANCE RATES

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	Empire EP Gold EPO 35/10%/5850	O/PPO * (EPOc) (UCR=N/A)	Health Gold Pro EPO* (E	First EPOc) (UCR=N/A)	Oso Classic Gold 0 *	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs						
Drug Card	10/35/75		10/50/85		10/50/100	
Cost Share Information						
Individual/Family Deductible	N/A		N/A		N/A	
Individual/Family OOP Limit	\$5,850/\$11,700		\$5,000/\$10,000 (incl ded)		\$5,000/\$10,000 (incl ded)	
Co-Insurance	10%		0%		0%	
Office Visits						
Primary Care	\$35		\$25		\$25	
Specialist	\$50		\$40		\$50	
Maternity Prenatal/Postnatal Care	No charge		No charge		No charge	
Chiropractic Care	\$50		\$40		\$50	
Inpatient Services						
Inpatient Hospital	\$500/day; 4 days/admit		\$500/day; \$1,500 max/admit		\$500/admit	
Mental Health Inpatient	\$500/day; 4 days/admit		\$500/day; \$1,500 max/admit		\$500/admit	
Substance Abuse Inpatient	\$500/day; 4 days/admit		\$500/day; \$1,500 max/admit		\$500/admit	
Outpatiant Sanciasa						
Outpatient Services	1			ř.		
Outpatient Facility	\$500		\$300		\$75	
Lab/X-Ray	Lab-No charge; X-ray: Office-No charge; OP- \$100		PCP-\$25; SP-\$40		Lab-\$25; X-ray-\$50	
Advanced Radiology	Office-\$50; OP-\$200		\$40		\$100	
Mental Health Outpatient Substance Abuse Outpatient	\$50 \$50		\$25 \$25		\$50 \$50	
Emergency Care	T T					
Emergency Room	\$350		\$350 (waived if admitted)		\$500	
Ambulance	\$350		\$150		\$500	
Urgent Care	\$100		\$60		\$75	
Recovery/Special Needs						
Home Health Care	\$50; 40 visits/yr		\$25; 40 visits/plan yr		\$25; 40 visits/plan yr	
Skilled Nursing	\$500/day; 4 days/admit; 200 days/yr		\$500/day; \$1,500 max/admit; 200 days/plan yr		\$500/admit; 200 days/plan yr	
Durable Medical Equipment	10%		15%		\$100	
Single	0 x \$891.04		0 x \$717.27		0 x \$717.16	5
EE with Spouse	0 x \$1,782.08		0 x \$1,434.54		0 x \$1,434.31	
EE with Child(ren)	0 x \$1,514.77		0 x \$1,219.36		0 x \$1,219.16	
Family	0 x \$2,539.46		0 x \$2,044.22		0 x \$2,043.89	
	NOC 0.0000000				0.50 1000 0000	
Monthly Cost	0 \$0.00		0 \$0.00)	0 \$0.00)
Annual Cost	\$0.00		\$0.00)	\$0.00)
	1		1		1	



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	Oxford Fre F Gold EPO 15/35 Non-Gat (UCR=N	ed OHI CNT* (EPOc)	Oxford L L Gold EPO 30/60 Gate (UCR=	ed OHI CNT* (EPOc)	Oxford M Silver EPO 30/60 Gat (UCR=	ed OHI CNT* (EPOc)
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs						
Drug Card	15/35/75/100 ded T2-3		15/35/75/100 ded T2-3		10/65/50%to\$800	
Cost Share Information						
Individual/Family Deductible	\$1,000/\$2,000		\$1,000/\$2,000		\$3,000/\$6,000	
Individual/Family OOP Limit	\$4,000/\$8,000 (incl ded)		\$4,000/\$8,000 (incl ded)		\$7,150/\$14,300 (incl ded)	
Co-Insurance	10%		0%		30%	
Office Visits						
Primary Care	\$15 ded waived		\$30 ded waived		\$30 ded waived	
Specialist	\$35 ded waived		\$60 ded waived		\$60 ded waived	
Maternity Prenatal/Postnatal Care	No charge		No charge		No charge	
Chiropractic Care	\$35 ded waived		\$60 ded waived		\$60 ded waived	
npatient Services	(1.1.1)					
Inpatient Hospital	10% after ded		\$500/day after ded; \$2,000 max/admit		30% after ded	
Mental Health Inpatient	10% after ded		\$500/day after ded; \$2,000 max/admit		30% after ded	
Substance Abuse Inpatient	Rehab-10% after ded		Rehab-\$500/day after ded; \$2,000 max/admit		Rehab-30% after ded	
Outpatient Convince						
Outpatient Services			1			
Outpatient Facility	Hosp-\$300 after ded; FS- \$150 after ded		Hosp-\$250 after ded; FS- \$150 after ded		30% after ded	
Lab/X-Ray	Lab-No charge; X-ray-\$80 after ded		Lab-No charge; X-ray-\$35 after ded		Lab-No charge; X-ray-30% after ded	
Advanced Radiology	\$150 after ded		\$100 after ded		30% after ded	
Mental Health Outpatient Substance Abuse Outpatient	\$35 ded waived Rehab-\$35 ded waived		\$60 ded waived Rehab-\$60 ded waived		\$60 ded waived Rehab-\$60 ded waived	
Emergency Care						
Emergency Room	\$400 (waived if admitted) ded waived		\$300 (waived if admitted) ded waived		30% after ded	
Ambulance	No charge		No charge		No chargo	
Ampulance Urgent Care	No charge \$75 ded waived		No charge \$75 ded waived		No charge \$80 ded waived	
Recovery/Special Needs						
Home Health Care	\$35 ded waived; 40 visits/contr yr		\$60 ded waived; 40 visits/contr yr		\$60 ded waived; 40 visits/contr yr	
Skilled Nursing	10% after ded; 200 days/contr yr		\$500/day after ded; \$2,000 max/admit; 200 days/contr yr		30% after ded; 200 days/contr yr	
Durable Medical Equipment	10% after ded		0% after ded		30% after ded	
Single	0 x \$881.86		0 x \$824.07		0 x \$587.57	
EE with Spouse	0 x \$1,763.71		0 x \$1,648.13		0 x \$1,175.15	
EE with Child(ren)	0 x \$1,499.16		0 x \$1,400.91		0 x \$998.88	
Family	0 x \$2,513.29		0 x \$2,348.59		0 x \$1,674.59	
	42,010120			2	0,014.00	
Monthly Cost	0 \$0.00		0 \$0.00		0 \$0.00	
Annual Cost	\$0.00		\$0.00		\$0.00	
Annual Cost	\$0.00		\$0.00	5	\$0.00	



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	Aetna Gold EPO 1000 90% ID: 14038844* (EPOc) (UCR=N/A)			
	In-Network	Out-Network		
Prescription Drugs				
Drug Card	15/65/50%/TCS/100 ded T2-4			
Cost Share Information				
Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Lifetime Maximum	\$1,000/\$2,000 embedded \$6,000/\$12,000 (incl ded) 10% None			
Office Visits				
Primary Care Specialist Adult Preventive Care Child Preventive Care Maternity Prenatal/Postnatal Care Rehabilitation Services	\$30 ded waived \$60 ded waived No charge; visit limits apply No charge; visit limits apply Pre-No charge; Post-refer to carrier \$60 ded waived; visit limits apply			
Chiroprostia Caro	\$60 ded waived			
Chiropractic Care Inpatient Services	500 ded walved			
Inpatient Hospital Inpatient Surgery Maternity Delivery/Inpatient	10% after ded Refer to Inpatient Hospital 10% after ded			
Mental Health Inpatient Substance Abuse Inpatient	10% after ded 10% after ded			
Outpatient Services				
Outpatient Facility Outpatient Surgery Lab/X-Ray	Refer to Outpatient Surgery 10% after ded 10% after ded			
Advanced Radiology Mental Health Outpatient Substance Abuse Outpatient	10% after ded \$60 ded waived \$60 ded waived			
Emergency Care Emergency Room Ambulance Urgent Care	\$750 (waived if admitted) ded waived 10% after ded \$75 ded waived			
Recovery/Special Needs				
Home Health Care	25% ded waived; 40 visits/cal yr			
Habilitation services	\$60 ded waived; visit limits apply			
Skilled Nursing	10% after ded			
Durable Medical Equipment Hospice Services	50% after ded 10% after ded			
Miscellaneous Services				
Pediatric Vision Exam Pediatric Vision Hardware Pediatric Dental Check-Up	50% after ded; 1 exam/12 mo 50% after ded; 1 pair/12 mo 0% after ded; 1 exam/6 mo			



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	EmblemHealth EmblemHealth Gold 40/60* (HMOc) (UCR=N/A)		
Procerintian Drugs	In-Network	Out-Network	
Prescription Drugs	15/35/75/100 ded		
Drug Card	13/33/73/100 ded		
Cost Share Information			
Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Lifetime Maximum	\$250/\$500 \$5,500/\$11,000 (incl ded) 0% None		
Office Visits			
Primary Care Specialist Adult Preventive Care Child Preventive Care Maternity Prenatal/Postnatal Care	\$40 after ded \$60 after ded No charge No charge No charge		
Rehabilitation Services	\$60 after ded; 60 visits/cond/plan yr comb PT/OT/ST; pre-auth req		
Chiropractic Care	\$60 after ded		
Inpatient Services			
Inpatient Hospital Inpatient Surgery Maternity Delivery/Inpatient	\$1,500/admit after ded; pre-auth req No charge; pre-auth req Delivery-No charge; IP-\$1,500/admit after ded; pre-auth req		
Mental Health Inpatient Substance Abuse Inpatient	\$1,500/admit after ded; pre-auth req \$1,500/admit after ded; pre-auth req		
Outpatient Services			
Outpatient Facility Outpatient Surgery Lab/X-Ray	\$150 after ded; pre-auth req No charge; pre-auth req \$60 after ded		
Advanced Radiology Mental Health Outpatient Substance Abuse Outpatient	\$60 after ded \$40 after ded \$40 after ded		
Emergency Care			
Emergency Room Ambulance Urgent Care	\$200 (waived if admitted) after ded \$100 after ded \$60 ded waived		
Recovery/Special Needs			
Home Health Care	\$40 after ded; 40 visits/plan yr; pre-auth req		
Habilitation services	\$60 after ded; 60 visits/cond/plan yr comb PT/OT/ST; pre-auth req		
Skilled Nursing	\$1,500/admit after ded; 200 days/plan yr; pre-auth req		
Durable Medical Equipment Hospice Services	10% after ded; pre-auth req \$1,500/admit after ded IP; \$40 after ded OP; 210 days/plan yr; pre-auth req		
Miscellaneous Services			
Pediatric Vision Exam Pediatric Vision Hardware Pediatric Dental Check-Up	\$40 after ded; 1 exam/12 mo 10% after ded; 1 pair/12 mo \$40 after ded; 1 exam/6 mo		



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	Empire Blue Priority Gold Blue Priority EPO 35/10%/5850* (EPOc) (UCR=N/A)		
	In-Network	Out-Network	
Prescription Drugs	in textion (
Drug Card	10/35/75		
Cost Share Information			
Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Lifetime Maximum	N/A \$5,850/\$11,700 10% None		
Office Visits			
Primary Care Specialist Adult Preventive Care Child Preventive Care Maternity Prenatal/Postnatal Care Rehabilitation Services	\$35 \$50 No charge No charge No charge \$50; 60 visits/yr comb PT/OT/ST		
Chiropractic Care	\$50		
Inpatient Services			
Inpatient Hospital Inpatient Surgery Maternity Delivery/Inpatient	\$500/day; 4 days/admit No charge \$500/day; 4 days/admit		
Mental Health Inpatient Substance Abuse Inpatient	\$500/day; 4 days/admit \$500/day; 4 days/admit		
Outpatient Services			
Outpatient Facility Outpatient Surgery Lab/X-Ray	\$500 No charge Lab-No charge; X-ray: Office-No charge; OP- \$100		
Advanced Radiology Mental Health Outpatient Substance Abuse Outpatient	Office-\$50; OP-\$200 \$50 \$50		
Emergency Care			
Emergency Room Ambulance Urgent Care	\$350 \$350 \$100		
Recovery/Special Needs			
Home Health Care	\$50; 40 visits/yr		
Habilitation services	\$50; 60 visits/yr comb PT/OT/ST		
Skilled Nursing	\$500/day; 4 days/admit; 200 days/yr		
Durable Medical Equipment Hospice Services	10% 10%		
Miscellaneous Services			
Pediatric Vision Exam Pediatric Vision Hardware Pediatric Dental Check-Up	No charge No charge No charge		



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	Empire EPO/PPO Gold EPO 35/10%/5850* (EPOc) (UCR=N/A)		
	In-Network	Out-Network	
Prescription Drugs	IIIIII	Out-Network	
Drug Card	10/35/75		
Cost Share Information			
ndividual/Family Deductible	N/A		
ndividual/Family OOP Limit	\$5,850/\$11,700		
Co-Insurance	10%		
Lifetime Maximum	None		
Office Visits			
Primary Care	\$35		
Specialist	\$50		
Adult Preventive Care	No charge		
Child Preventive Care Maternity Prenatal/Postnatal Care	No charge		
viaternity Frenatal/Fostilatal Care	No charge		
Rehabilitation Services	\$50; 60 visits/yr comb PT/OT/ST		
Chiropractic Care	\$50		
Inpatient Services			
Inpatient Hospital	\$500/day; 4 days/admit		
npatient Surgery	No charge		
Maternity Delivery/Inpatient	\$500/day; 4 days/admit		
Mental Health Inpatient Substance Abuse Inpatient	\$500/day; 4 days/admit \$500/day; 4 days/admit		
Outpatient Services			
Outpatient Facility	\$500		
Outpatient Surgery	No charge		
Lab/X-Ray	Lab-No charge; X-ray: Office-No charge; OP- \$100		
Advanced Radiology	Office-\$50; OP-\$200		
Mental Health Outpatient	\$50		
Substance Abuse Outpatient	\$50		
Emergency Care			
Emergency Room	\$350		
Ambulance	\$350		
Urgent Care	\$100		
Recovery/Special Needs			
Home Health Care	\$50; 40 visits/yr		
Habilitation services	\$50; 60 visits/yr comb PT/OT/ST		
Skilled Nursing	\$500/day; 4 days/admit; 200 days/yr		
Durable Medical Equipment	10%		
Durable Medical Equipment Hospice Services	10% 10%		
Miscellaneous Services			
Pediatric Vision Exam	No charge		
Pediatric Vision Hardware	No charge		



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	HealthFirst			
	Gold Pro EPO* (EPOc) (UCR=N/A)			
	In-Network	Out-Network		
Prescription Drugs				
Drug Card	10/50/85			
Cost Share Information				
Individual/Family Deductible Individual/Family OOP Limit Co-Insurance	N/A \$5,000/\$10,000 (incl ded) 0%			
Lifetime Maximum	None			
Office Visits				
Primary Care Specialist Adult Preventive Care Child Preventive Care Maternity Prenatal/Postnatal Care	\$25 \$40 No charge No charge No charge			
Rehabilitation Services	\$40; 60 visits/cond/plan yr comb PT/OT/ST			
Chiropractic Care	\$40			
Inpatient Services				
Inpatient Hospital Inpatient Surgery Maternity Delivery/Inpatient	\$500/day; \$1,500 max/admit \$300 Delivery-\$100; IP-\$500/day; \$1,500 max/adm	it		
Mental Health Inpatient Substance Abuse Inpatient	\$500/day; \$1,500 max/admit \$500/day; \$1,500 max/admit			
Outpatient Services				
Outpatient Facility Outpatient Surgery Lab/X-Ray	\$300 \$300 PCP-\$25; SP-\$40			
Advanced Radiology Mental Health Outpatient Substance Abuse Outpatient	\$40 \$25 \$25			
Emergency Care				
Emergency Room Ambulance Urgent Care	\$350 (waived if admitted) \$150 \$60			
Recovery/Special Needs				
Home Health Care	\$25; 40 visits/plan yr			
Habilitation services	\$40; 60 visits/cond/plan yr comb PT/OT/ST			
Skilled Nursing	\$500/day; \$1,500 max/admit; 200 days/plan y	r		
Durable Medical Equipment Hospice Services	15% \$500/day; \$1,500 max/admit IP; \$25 OP; 210 days/plan yr			
Miscellaneous Services				
Pediatric Vision Exam Pediatric Vision Hardware Pediatric Dental Check-Up	\$10; 1 exam/yr \$25; 1 pair/yr \$25; 2 visits/yr			



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1Q - NYC - For New Groups Starting First Quarter 2018

	Oscar Classic Gold 0 * (EPO) (UCR=N/A)		
	In-Network	Out-Network	
Prescription Drugs			
Drug Card	10/50/100		
Cost Share Information			
Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Lifetime Maximum	N/A \$5,000/\$10,000 (incl ded) 0% None		
Office Visits			
Primary Care Specialist Adult Preventive Care Child Preventive Care Maternity Prenatal/Postnatal Care	\$25 \$50 No charge No charge No charge		
Rehabilitation Services	\$50; 60 visits/cond/plan yr comb PT/OT/ST		
Chiropractic Care	\$50		
Inpatient Services			
Inpatient Hospital Inpatient Surgery Maternity Delivery/Inpatient	\$500/admit \$100 Delivery-\$100; IP-\$500/admit		
Mental Health Inpatient Substance Abuse Inpatient	\$500/admit \$500/admit		
Outpatient Services			
Outpatient Facility Outpatient Surgery Lab/X-Ray	\$75 \$75 Lab-\$25; X-ray-\$50		
Advanced Radiology Mental Health Outpatient Substance Abuse Outpatient	\$100 \$50 \$50		
Emergency Care			
Emergency Room Ambulance Urgent Care	\$500 \$500 \$75		
Recovery/Special Needs			
Home Health Care	\$25; 40 visits/plan yr		
Habilitation services	\$50; 60 visits/cond/plan yr comb PT/OT/ST		
Skilled Nursing	\$500/admit; 200 days/plan yr		
Durable Medical Equipment Hospice Services	\$100 \$500/admit IP; \$25 OP; 210 days/yr		
Miscellaneous Services			
Pediatric Vision Exam Pediatric Vision Hardware Pediatric Dental Check-Up	\$25; 1 exam/12 mo \$100; 1 pair/12 mo \$100; 1 exam/6 mo		



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1Q - NYC - For New Groups Starting First Quarter 2018

	Oxford Freedom F Gold EPO 15/35 Non-Gated OHI CNT* (EPOc) (UCR=N/A)		
Prescription Drugs	In-Network	Out-Network	
Drug Card	15/35/75/100 ded T2-3		
Cost Share Information			
Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Lifetime Maximum	\$1,000/\$2,000 \$4,000/\$8,000 (incl ded) 10% None		
Office Visits			
Primary Care Specialist Adult Preventive Care Child Preventive Care Maternity Prenatal/Postnatal Care	\$15 ded waived \$35 ded waived No charge No charge No charge		
Rehabilitation Services	\$35 ded waived; 60 visits/contr yr comb PT/OT/ST		
Chiropractic Care	\$35 ded waived		
Inpatient Services			
Inpatient Hospital Inpatient Surgery Maternity Delivery/Inpatient	10% after ded 10% after ded 10% after ded		
Mental Health Inpatient Substance Abuse Inpatient	10% after ded Rehab-10% after ded		
Outpatient Services			
Outpatient Facility Outpatient Surgery Lab/X-Ray	Hosp-\$300 after ded; FS-\$150 after ded Included in Outpatient Facility Lab-No charge; X-ray-\$80 after ded		
Advanced Radiology Mental Health Outpatient Substance Abuse Outpatient	\$150 after ded \$35 ded waived Rehab-\$35 ded waived		
Emergency Care			
Emergency Room Ambulance Urgent Care	\$400 (waived if admitted) ded waived No charge \$75 ded waived		
Recovery/Special Needs			
Home Health Care	\$35 ded waived; 40 visits/contr yr		
Habilitation services	\$35 ded waived; 60 visits/contr yr comb PT/OT/ST		
Skilled Nursing	10% after ded; 200 days/contr yr		
Durable Medical Equipment Hospice Services	10% after ded 10% after ded IP; \$35 ded waived OP		
Miscellaneous Services			
Pediatric Vision Exam Pediatric Vision Hardware Pediatric Dental Check-Up	\$15 ded waived 50% ded waived 0% after ded		



2018 SMALL GROUP HEALTH INSURANCE RATES

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	Oxford Liberty L Gold EPO 30/60 Gated OHI CNT* (EPOc) (UCR=N/A)	
	in-Network	Out-Network
Prescription Drugs	Introducin	Out-Network
Drug Card	15/35/75/100 ded T2-3	
Cost Share Information		
Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Lifetime Maximum	\$1,000/\$2,000 \$4,000/\$8,000 (incl ded) 0% None	
Office Visits		
Primary Care Specialist Adult Preventive Care Child Preventive Care Maternity Prenatal/Postnatal Care	\$30 ded waived \$60 ded waived No charge No charge	
Rehabilitation Services	\$60 ded waived; 60 visits/contr yr comb PT/OT/ST	
Chiropractic Care	\$60 ded waived	
Inpatient Services		
Inpatient Hospital Inpatient Surgery Maternity Delivery/Inpatient	\$500/day after ded; \$2,000 max/admit 0% after ded \$500/day after ded; \$2,000 max/admit	
Mental Health Inpatient Substance Abuse Inpatient	\$500/day after ded; \$2,000 max/admit Rehab-\$500/day after ded; \$2,000 max/admit	
Outpatient Services		
Outpatient Facility Outpatient Surgery Lab/X-Ray	Hosp-\$250 after ded; FS-\$150 after ded Included in Outpatient Facility Lab-No charge; X-ray-\$35 after ded	
Advanced Radiology Mental Health Outpatient Substance Abuse Outpatient	\$100 after ded \$60 ded waived Rehab-\$60 ded waived	
Emergency Care		
Emergency Room Ambulance Urgent Care	\$300 (waived if admitted) ded waived No charge \$75 ded waived	
Recovery/Special Needs		
Home Health Care	\$60 ded waived; 40 visits/contr yr	
Habilitation services	\$60 ded waived; 60 visits/contr yr comb PT/OT/ST	
Skilled Nursing	\$500/day after ded; \$2,000 max/admit; 200 days/contr yr	
Durable Medical Equipment Hospice Services	0% after ded \$500/day after ded; \$2,000 max/admit IP; \$60 ded waived OP	
Miscellaneous Services		
Pediatric Vision Exam Pediatric Vision Hardware Pediatric Dental Check-Up	\$30 ded waived 50% ded waived 0% after ded	



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1Q - NYC - For New Groups Starting First Quarter 2018

	Oxford Metro M Silver EPO 30/60 Gated OHI CNT* (EPOc) (UCR=N/A)	
Prescription Drugs	In-Network	Out-Network
Drug Card	10/65/50%to\$800	
Cost Share Information		
Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Lifetime Maximum	\$3,000/\$6,000 \$7,150/\$14,300 (incl ded) 30% None	
Office Visits		
Primary Care Specialist Adult Preventive Care Child Preventive Care Maternity Prenatal/Postnatal Care	\$30 ded waived \$60 ded waived No charge No charge No charge	
Rehabilitation Services	\$60 ded waived; 60 visits/contr yr comb PT/OT/ST	
Chiropractic Care	\$60 ded waived	
Inpatient Services		
Inpatient Hospital Inpatient Surgery Maternity Delivery/Inpatient	30% after ded 30% after ded 30% after ded	
Mental Health Inpatient Substance Abuse Inpatient	30% after ded Rehab-30% after ded	
Outpatient Services		
Outpatient Facility Outpatient Surgery Lab/X-Ray	30% after ded 30% after ded Lab-No charge; X-ray-30% after ded	
Advanced Radiology Mental Health Outpatient Substance Abuse Outpatient	30% after ded \$60 ded waived Rehab-\$60 ded waived	
Emergency Care		
Emergency Room Ambulance Urgent Care	30% after ded No charge \$80 ded waived	
Recovery/Special Needs		
Home Health Care	\$60 ded waived; 40 visits/contr yr	
Habilitation services	\$60 ded waived; 60 visits/contr yr comb PT/OT/ST	
Skilled Nursing	30% after ded; 200 days/contr yr	
Durable Medical Equipment Hospice Services	30% after ded 30% after ded IP; \$60 ded waived OP	
Miscellaneous Services		
Pediatric Vision Exam Pediatric Vision Hardware Pediatric Dental Check-Up	\$30 ded waived 50% ded waived 0% after ded	