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2018 SMALL GROUP HEALTH INSURANCE RATES

4Q - NYC - For New Groups Starting Fourth 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 25/0%/6000* (EPO) (UCR=N/A)	HealthFirst Gold Pro EPO* (EPOc) (UCR=N/A)	Oscar Classic Gold 0 * (EPO) (UCR=N/A)	Oxford Metro M Gold EPO 25/40 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	10/65/50%to$800	15/35/75/100 ded T2-3
In-Network								
Ind/Fam Deductible	$1,000/$2,000 embedded	$250/$500	N/A	N/A	N/A	N/A	$1,250/$2,500	$1,000/$2,000
Ind/Fam OOP Limit	$6,000/$12,000 (incl ded)	$5,500/$11,000 (incl ded)	$5,850/$11,700	$6,000/$12,000	$5,000/$10,000 (incl ded)	$5,000/$10,000 (incl ded)	$5,500/$11,000 (incl ded)	$4,000/$8,000 (incl ded)
Co-Insurance	10%	0%	10%	0%	0%	0%	20%	0%
Primary Care	$30 ded waived	$40 after ded	$35	$25	$25	$25	$25 ded waived	$30 ded waived
Specialist	$60 ded waived	$60 after ded	$50	$50	$40	$50	$40 ded waived	$60 ded waived
Inpatient Hospital	10% after ded	$1,500/admit after ded; pre-auth req	$500/day; 4 days/admit	$350/day; 4 days max/admit	$500/day; $1,500 max/admit	$500/admit	20% after ded	$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	**0 x $964.04**	**0 x $770.76**	**0 x $893.83**	**0 x $984.24**	**0 x $750.03**	**0 x $761.05**	**0 x $733.62**	**0 x $882.31**
EE with Spouse	**0 x $1,928.08**	**0 x $1,541.53**	**0 x $1,787.66**	**0 x $1,968.48**	**0 x $1,500.06**	**0 x $1,522.10**	**0 x $1,467.23**	**0 x $1,764.62**
EE with Child(ren)	**0 x $1,638.87**	**0 x $1,310.30**	**0 x $1,519.51**	**0 x $1,673.21**	**0 x $1,275.05**	**0 x $1,293.79**	**0 x $1,247.15**	**0 x $1,499.93**
Family	**0 x $2,747.52**	**0 x $2,196.69**	**0 x $2,547.42**	**0 x $2,805.08**	**0 x $2,137.59**	**0 x $2,169.00**	**0 x $2,090.81**	**0 x $2,514.59**
Monthly Cost	**0 $0.00**	**0 $0.00**	**0 $0.00**	**0 $0.00**	**0 $0.00**	**0 $0.00**	**0 $0.00**	**0 $0.00**
Annual Cost	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

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	Oxford Freedom F Gold EPO 15/35 Non-Gated OHI CNT* (EPOc) (UCR=N/A)		
Prescription Drugs			
Drug Card	15/35/75/100 ded T2-3		
In-Network			
Ind/Fam Deductible	$1,000/$2,000		
Ind/Fam OOP Limit	$4,000/$8,000 (incl ded)		
Co-Insurance	10%		
Primary Care	$15 ded waived		
Specialist	$35 ded waived		
Inpatient Hospital	10% after ded		
Out-Network			
Ind/Fam Deductible			
Ind/Fam OOP Limit			
Co-Insurance			
Primary Care			
Specialist			
Inpatient Hospital			
Single		**0 x**	**$944.19**
EE with Spouse		**0 x**	**$1,888.38**
EE with Child(ren)		**0 x**	**$1,605.12**
Family		**0 x**	**$2,690.94**
Monthly Cost		**0**	**$0.00**
Annual Cost			**$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	$1,000/$2,000 embedded	
Individual/Family OOP Limit	$6,000/$12,000 (incl ded)	
Co-Insurance	10%	
Lifetime Maximum	None	
Office Visits		
Primary Care	$30 ded waived	
Specialist	$60 ded waived	
Adult Preventive Care	No charge; visit limits apply	
Child Preventive Care	No charge; visit limits apply	
Maternity Prenatal/Postnatal Care	Pre-No charge; Post-refer to carrier	
Rehabilitation Services	$60 ded waived; visit limits apply	
Chiropractic Care	$60 ded waived	
Inpatient Services		
Inpatient Hospital	10% after ded	
Inpatient Surgery	Refer to Inpatient Hospital	
Maternity Delivery/Inpatient	10% after ded	
Mental Health Inpatient	10% after ded	
Substance Abuse Inpatient	10% after ded	
Outpatient Services		
Outpatient Facility	Refer to Outpatient Surgery	
Outpatient Surgery	10% after ded	
Lab/X-Ray	10% after ded	
Advanced Radiology	10% after ded	
Mental Health Outpatient	$60 ded waived	
Substance Abuse Outpatient	$60 ded waived	
Emergency Care		
Emergency Room	$750 (waived if admitted) ded waived	
Ambulance	10% after ded	
Urgent Care	$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	50% after ded	
Hospice Services	10% after ded	
Miscellaneous Services		
Pediatric Vision Exam	50% after ded; 1 exam/12 mo	
Pediatric Vision Hardware	50% after ded; 1 pair/12 mo	
Pediatric Dental Check-Up	0% after ded; 1 exam/6 mo	

2018 SMALL GROUP HEALTH INSURANCE RATES

4Q - NYC - For New Groups Starting Fourth Quarter 2018

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

2018 SMALL GROUP HEALTH INSURANCE RATES

4Q - NYC - For New Groups Starting Fourth Quarter 2018

	Empire Blue Priority Gold Blue Priority EPO 35/10%/5850* (EPOc) (UCR=N/A)	
	In-Network	Out-Network
Prescription Drugs		
Drug Card	10/35/75	
Cost Share Information		
Individual/Family Deductible	N/A	
Individual/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	No charge	
Maternity Prenatal/Postnatal 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	
Inpatient Surgery	No charge	
Maternity Delivery/Inpatient	$500/day; 4 days/admit	
Mental Health Inpatient	$500/day; 4 days/admit	
Substance Abuse Inpatient	$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%	
Hospice Services	10%	
Miscellaneous Services		
Pediatric Vision Exam	No charge	
Pediatric Vision Hardware	No charge	
Pediatric Dental Check-Up	No charge	

2018 SMALL GROUP HEALTH INSURANCE RATES

4Q - NYC - For New Groups Starting Fourth Quarter 2018

	Empire EPO/PPO Gold EPO 25/0%/6000* (EPO) (UCR=N/A)	
	In-Network	Out-Network
Prescription Drugs		
Drug Card	10/35/75	
Cost Share Information		
Individual/Family Deductible	N/A	
Individual/Family OOP Limit	$6,000/$12,000	
Co-Insurance	0%	
Lifetime Maximum	None	
Office Visits		
Primary Care	$25	
Specialist	$50	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	$50; 60 visits/yr comb PT/OT/ST	
Chiropractic Care	$50	
Inpatient Services		
Inpatient Hospital	$350/day; 4 days max/admit	
Inpatient Surgery	No charge	
Maternity Delivery/Inpatient	$350/day; 4 days max/admit	
Mental Health Inpatient	$350/day; 4 days max/admit	
Substance Abuse Inpatient	$350/day; 4 days max/admit	
Outpatient Services		
Outpatient Facility	$300	
Outpatient Surgery	No charge	
Lab/X-Ray	Lab-No charge; X-ray: Office-No charge; OP-$50	
Advanced Radiology	Office-$50; OP-$150	
Mental Health Outpatient	$50	
Substance Abuse Outpatient	$50	
Emergency Care		
Emergency Room	$300	
Ambulance	$300	
Urgent Care	$75	
Recovery/Special Needs		
Home Health Care	$50; 40 visits/yr	
Habilitation services	$50; 60 visits/yr comb PT/OT/ST	
Skilled Nursing	$350/day; 4 days max/admit; 200 days/yr	
Durable Medical Equipment	No charge	
Hospice Services	No charge	
Miscellaneous Services		
Pediatric Vision Exam	No charge	
Pediatric Vision Hardware	No charge	
Pediatric Dental Check-Up	No charge	

2018 SMALL GROUP HEALTH INSURANCE RATES

4Q - NYC - For New Groups Starting Fourth Quarter 2018

	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	N/A	
Individual/Family OOP Limit	$5,000/$10,000 (incl ded)	
Co-Insurance	0%	
Lifetime Maximum	None	
Office Visits		
Primary Care	$25	
Specialist	$40	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	$40; 60 visits/cond/plan yr comb PT/OT/ST	
Chiropractic Care	$40	
Inpatient Services		
Inpatient Hospital	$500/day; $1,500 max/admit	
Inpatient Surgery	$300	
Maternity Delivery/Inpatient	Delivery-$100; IP-$500/day; $1,500 max/admit	
Mental Health Inpatient	$500/day; $1,500 max/admit	
Substance Abuse Inpatient	$500/day; $1,500 max/admit	
Outpatient Services		
Outpatient Facility	$300	
Outpatient Surgery	$300	
Lab/X-Ray	PCP-$25; SP-$40	
Advanced Radiology	$40	
Mental Health Outpatient	$25	
Substance Abuse Outpatient	$25	
Emergency Care		
Emergency Room	$350 (waived if admitted)	
Ambulance	$150	
Urgent Care	$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 yr	
Durable Medical Equipment	15%	
Hospice Services	$500/day; $1,500 max/admit IP; $25 OP; 210 days/plan yr	
Miscellaneous Services		
Pediatric Vision Exam	$10; 1 exam/yr	
Pediatric Vision Hardware	$25; 1 pair/yr	
Pediatric Dental Check-Up	$25; 2 visits/yr	

2018 SMALL GROUP HEALTH INSURANCE RATES

4Q - NYC - For New Groups Starting Fourth 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	N/A	
Individual/Family OOP Limit	$5,000/$10,000 (incl ded)	
Co-Insurance	0%	
Lifetime Maximum	None	
Office Visits		
Primary Care	$25	
Specialist	$50	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	$50; 60 visits/cond/plan yr comb PT/OT/ST	
Chiropractic Care	$50	
Inpatient Services		
Inpatient Hospital	$500/admit	
Inpatient Surgery	$100	
Maternity Delivery/Inpatient	Delivery-$100; IP-$500/admit	
Mental Health Inpatient	$500/admit	
Substance Abuse Inpatient	$500/admit	
Outpatient Services		
Outpatient Facility	$75	
Outpatient Surgery	$75	
Lab/X-Ray	Lab-$25; X-ray-$50	
Advanced Radiology	$100	
Mental Health Outpatient	$50	
Substance Abuse Outpatient	$50	
Emergency Care		
Emergency Room	$500	
Ambulance	$500	
Urgent Care	$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	$100	
Hospice Services	$500/admit IP; $25 OP; 210 days/yr	
Miscellaneous Services		
Pediatric Vision Exam	$25; 1 exam/12 mo	
Pediatric Vision Hardware	$100; 1 pair/12 mo	
Pediatric Dental Check-Up	$100; 1 exam/6 mo	

2018 SMALL GROUP HEALTH INSURANCE RATES

4Q - NYC - For New Groups Starting Fourth Quarter 2018

	Oxford Metro M Gold EPO 25/40 Gated OHI CNT* (EPOc) (UCR=N/A)	
	In-Network	Out-Network
Prescription Drugs		
Drug Card	10/65/50%to$800	
Cost Share Information		
Individual/Family Deductible	$1,250/$2,500	
Individual/Family OOP Limit	$5,500/$11,000 (incl ded)	
Co-Insurance	20%	
Lifetime Maximum	None	
Office Visits		
Primary Care	$25 ded waived	
Specialist	$40 ded waived	
Adult Preventive Care	No charge	
Child Preventive Care	No charge	
Maternity Prenatal/Postnatal Care	No charge	
Rehabilitation Services	$40 ded waived; 60 visits/contr yr comb PT/OT/ST	
Chiropractic Care	$40 ded waived	
Inpatient Services		
Inpatient Hospital	20% after ded	
Inpatient Surgery	20% after ded	
Maternity Delivery/Inpatient	20% after ded	
Mental Health Inpatient	20% after ded	
Substance Abuse Inpatient	Rehab-20% after ded	
Outpatient Services		
Outpatient Facility	Hosp-$500 after ded; FS-$200 after ded	
Outpatient Surgery	Included in Outpatient Facility	
Lab/X-Ray	Lab-No charge; X-ray-$50 after ded	
Advanced Radiology	$150 after ded	
Mental Health Outpatient	$40 ded waived	
Substance Abuse Outpatient	Rehab-$40 ded waived	
Emergency Care		
Emergency Room	$500 (waived if admitted) ded waived	
Ambulance	No charge	
Urgent Care	$65 ded waived	
Recovery/Special Needs		
Home Health Care	$40 ded waived; 40 visits/contr yr	
Habilitation services	$40 ded waived; 60 visits/contr yr comb PT/OT/ST	
Skilled Nursing	20% after ded; 200 days/contr yr	
Durable Medical Equipment	20% after ded	
Hospice Services	20% after ded IP; $40 ded waived OP	
Miscellaneous Services		
Pediatric Vision Exam	$25 ded waived	
Pediatric Vision Hardware	50% ded waived	
Pediatric Dental Check-Up	0% after ded	

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

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

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NEW YORK-SITUSED BUSINESS:

- Dental – UnitedHealthcare 2-50 – Plan A7848 – Contributory Plan
- 100% Preventive, 80% Basic, 50% Major, $1,000 Maximum, MAC, $50 Deductible

ZIP CODES: 110, 115, 117, 118 & 119					ZIP CODES: 100-109, 111-114 & 116			
Group Size	Employee	Spouse	Child	Family	Employee	Spouse	Child	Family
2-9	$37.95	$75.90	$76.72	$119.84	$37.87	$75.75	$76.55	$119.59
10-50	$29.59	$59.18	$59.81	$93.43	$29.53	$59.06	$59.69	$93.24

- Vision – UnitedHealthcare (2-99) – Plan V1043 – Voluntary – Only One Employee Needs to Enroll
- 12-Month Frequency for Exams & Lenses, 24-Month Frequency for Frames, $15/$30 Deductible, Spectera Network

GROUP SIZE	NEW YORK STATE			
	Employee	Spouse	Child	Family
2-99	$4.44	$8.44	$9.86	$13.90

Note: The above plans and pricing are only a sample of the available plans for the New York market. Prices are subject to change.

LET'S TALK

Contact us for more options and customized proposals from our carrier partners.

Disclosure

NY Commission Disclosure

New York Regulation (11 NYCRR 30)) requires disclosure of the compensation a licensed agent or broker (producer) receives from your purchase or renewal of health coverage. Compensation may be in the form of a commission, fee(s), or possibly other valuable consideration, or acombination of all three. Total commission levels per carrier are as follows: Aetna - 1-100 NY SG commissions for 2018 (new and renewal) are set at $20 PEPM ; Emblem 3%-4% depending on selected plan; HealthPass -same as commission paid by carrier; Oxford-3%. An additional commission will be paid to a general agent if they are involved in the sale; this amount may vary based on carrier and plan design. The commissions do not directly affect the premium paid for the plan and no plan can be purchased through another distributor or from the carrier directly with a different commission amount or at a lower cost. Final commission dollar amounts cannot be determined until enrollment is complete and is subject to change based on the number of members covered each month.