

Prepared For: **Emblem 2017 3rd qtr NY City**

New York County, NY 10001

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

**Health Plan Comparison Report (4L)**

Effective Date: 07/01/2017

Prepared On: 04/21/2017

Report ID: 32849321

SIC: 0000

	EmblemHealth Select Care Platinum HMO 15/35		EmblemHealth Select Care Silver Value 35/55		EmblemHealth Select Care Gold HMO 40/60		EmblemHealth Select Care Bronze Value HD 7150	
	In-Network		In-Network		In-Network		In-Network	
Prescription Drugs								
Drug Card	10/30/60		0%/0%/0% IntDed T2-3		15/35/75/100 ded		30/0%/0% IntDed T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		\$5,800/\$11,600		\$250/\$500		\$7,150/\$14,300	
Individual/Family OOP Limit	\$2,000/\$4,000		\$5,800/\$11,600 (incl ded)		\$5,500/\$11,000 (incl ded)		\$7,150/\$14,300 (incl ded)	
Co-Insurance	0%		0%		0%		0%	
Office Visits								
Primary Care	\$15		No charge visits 1-3; \$35 ded waived visits 4+		\$40 after ded		No charge visits 1-2; 0% after ded visits 3+	
Specialist	\$35		\$55 ded waived		\$60 after ded		0% after ded	
Inpatient Services								
Inpatient Hospital	\$500/admit; pre-auth req		0% after ded; pre-auth req		\$1,500/admit after ded; pre-auth req		0% after ded; pre-auth req	
Mental Health Inpatient	\$500/admit; pre-auth req		0% after ded; pre-auth req		\$1,500/admit after ded; pre-auth req		0% after ded; pre-auth req	
Outpatient Services								
Outpatient Facility	\$100; pre-auth req		0% after ded; pre-auth req		\$150 after ded; pre-auth req		0% after ded; pre-auth req	
Lab/X-Ray	PCP-\$15; SP-\$35		No charge		PCP-\$40 after ded; SP-\$60 after ded		No charge	
Mental Health Outpatient	\$15		\$35 ded waived		\$40 after ded		0% after ded	
Emergency Care								
Emergency Room	\$100 (waived if admitted)		0% after ded		\$200 (waived if admitted) after ded		0% after ded	
Urgent Care	\$55		\$75 ded waived		\$60 after ded		0% after ded	
Single	1 x	\$848.58	1 x	\$549.09	1 x	\$701.91	1 x	\$490.94
EE with Spouse	0 x	\$1,697.18	0 x	\$1,098.17	0 x	\$1,403.83	0 x	\$981.88
EE with Child(ren)	0 x	\$1,442.60	0 x	\$933.45	0 x	\$1,193.26	0 x	\$834.60
Family	1 x	\$2,418.48	1 x	\$1,564.90	1 x	\$2,000.45	1 x	\$1,399.18
Monthly Cost	2	\$3,267.06	2	\$2,113.99	2	\$2,702.36	2	\$1,890.12
Annual Cost		\$39,204.72		\$25,367.88		\$32,428.32		\$22,681.44

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