

	EmblemHealth EH Platinum Premier NG Prime (HMO) (UCR=N/A)		EmblemHealth EH Gold Premier NG Prime (HMOc) (UCR=N/A)		EmblemHealth EH Gold Plus G Prime (HMOc) (UCR=N/A)		EmblemHealth EH Gold Premier 1 NG Prime (HMOc) (UCR=N/A)	
	In-Network		In-Network		In-Network		In-Network	
Prescription Drugs								
Drug Card	15/30/70		10/30/70		15/30/70		15/45/70/100 ded T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		\$450/\$900		\$550/\$1,100		\$2,000/\$4,000	
Individual/Family OOP Limit	\$2,000/\$4,000		\$4,000/\$8,000 (incl ded)		\$4,500/\$9,000 (incl ded)		\$6,800/\$13,600 (incl ded)	
Co-Insurance	0%		0%		0%		30%	
Office Visits								
Primary Care	No charge visits 1-3; \$15 visits 4+		No charge visits 1-3; \$30 ded waived visits 4+		No charge visits 1-3; \$40 ded waived visits 4+		\$30 ded waived	
Specialist	\$35		\$50 ded waived		\$60 ded waived		\$60 ded waived	
Inpatient Services								
Inpatient Hospital	\$500/admit; pre-auth req		\$1,000/admit after ded		\$1,500/admit after ded; pre-auth req		30% after ded	
Mental Health Inpatient	\$500/admit; pre-auth req		\$1,000/admit after ded		\$1,500/admit after ded; pre-auth req		30% after ded	
Outpatient Services								
Outpatient Facility	\$100; pre-auth req		\$150 after ded		\$150 after ded; pre-auth req		30% after ded	
Lab/X-Ray	PCP-\$15; SP-\$35		Lab-PCP-\$30 ded waived; SP-\$50 ded waived; X-ray-PCP-\$30 after ded; SP-\$50 after ded		Lab-PCP-\$40 ded waived; SP-\$60 ded waived/X-ray-PCP-\$40 after ded; SP-\$60 after ded		Lab-No charge; X-ray-30% after ded	
Mental Health Outpatient	\$15		\$30 ded waived		\$40 ded waived		\$60 ded waived	
Emergency Care								
Emergency Room	\$200 (waived if admitted)		\$300 (waived if admitted) after ded		\$300 (waived if admitted) after ded		\$500 (waived if admitted) after ded	
Urgent Care	\$75		\$75 ded waived		\$75 ded waived		\$75 ded waived	
Single	1 x	\$1,066.58	1 x	\$937.16	1 x	\$877.53	1 x	\$826.39
EE with Spouse	0 x	\$2,133.18	0 x	\$1,874.30	0 x	\$1,755.05	0 x	\$1,652.78
EE with Child(ren)	0 x	\$1,813.20	0 x	\$1,593.16	0 x	\$1,491.80	0 x	\$1,404.87
Family	1 x	\$3,039.76	1 x	\$2,670.88	1 x	\$2,500.95	1 x	\$2,355.22
Monthly Cost	2	\$4,106.34	2	\$3,608.04	2	\$3,378.48	2	\$3,181.61
Annual Cost		\$49,276.08		\$43,296.48		\$40,541.76		\$38,179.32

	EmblemHealth EH Gold Plus 1 G Prime (HMOc) (UCR=N/A)		EmblemHealth EH Silver Premier NG Prime (HMOc) (UCR=N/A)		EmblemHealth EH Silver Plus 1 NG Prime (HMOc) (UCR=N/A)		EmblemHealth EH Silver Premier 1 G Prime (HMOc) (UCR=N/A)	
	In-Network		In-Network		In-Network		In-Network	
Prescription Drugs								
Drug Card	15/35/75/100 ded T2-3		15/35/75		15/65/85/200 ded T2-3		20/45/75/200 ded T2-3	
Cost Share Information								
Individual/Family Deductible	\$1,000/\$2,000		\$3,300/\$6,600		\$3,000/\$6,000		\$2,700/\$5,400	
Individual/Family OOP Limit	\$4,000/\$8,000 (incl ded)		\$7,000/\$14,000 (incl ded)		\$7,000/\$14,000 (incl ded)		\$7,300/\$14,600 (incl ded)	
Co-Insurance	0%		0%		50%		30%	
Office Visits								
Primary Care	\$30 ded waived		No charge visits 1-3; \$30 ded waived visits 4+		\$35 ded waived		\$40 ded waived	
Specialist	\$60 ded waived		\$55 ded waived		\$55 ded waived		\$70 ded waived	
Inpatient Services								
Inpatient Hospital	\$500/day after ded; \$2,000 max/admit; pre-auth req		\$2,000/admit after ded		50% after ded		30% after ded; pre-auth req	
Mental Health Inpatient	\$500/day after ded; \$2,000 max/admit; pre-auth req		\$2,000/admit after ded		50% after ded		30% after ded; pre-auth req	
Outpatient Services								
Outpatient Facility	\$250 after ded; pre-auth req		\$200 after ded		50% after ded		30% after ded; pre-auth req	
Lab/X-Ray	Lab-No charge; X-ray-PCP-\$30 after ded; SP-\$60 after ded		Lab-PCP-\$30 ded waived; SP-\$55 ded waived; X-ray-PCP-\$30 after ded; SP-\$55 after ded		Lab-\$35 ded waived; X-ray-50% after ded		Lab-\$40 ded waived; X-ray-30% after ded	
Mental Health Outpatient	\$60 ded waived		\$30 ded waived		\$55 ded waived		\$70 ded waived	
Emergency Care								
Emergency Room	\$300 (waived if admitted) after ded		\$500 (waived if admitted) after ded		\$700 (waived if admitted) after ded		30% after ded	
Urgent Care	\$75 ded waived		\$75 ded waived		\$75 ded waived		\$75 ded waived	
Single	1 x	\$819.26	1 x	\$730.00	1 x	\$718.73	1 x	\$706.73
EE with Spouse	0 x	\$1,638.53	0 x	\$1,460.02	0 x	\$1,437.46	0 x	\$1,413.44
EE with Child(ren)	0 x	\$1,392.75	0 x	\$1,241.01	0 x	\$1,221.84	0 x	\$1,201.44
Family	1 x	\$2,334.89	1 x	\$2,080.51	1 x	\$2,048.38	1 x	\$2,014.16
Monthly Cost	2	\$3,154.15	2	\$2,810.51	2	\$2,767.11	2	\$2,720.89
Annual Cost		\$37,849.80		\$33,726.12		\$33,205.32		\$32,650.68

Prepared For: **Emblem 2019 3rd qtr Pime NY City**

New York County, NY 10001

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

Health Plan Comparison Report (4L)

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SIC: 0000

	EmblemHealth EH Silver Plus G Prime (HMOc) (UCR=N/A)		EmblemHealth EH Bronze Plus HSA G Prime (HSA) (UCR=N/A)	
	In-Network		In-Network	Out-Network
Prescription Drugs				
Drug Card	20/40/75		10/35/75 IntDed	
Cost Share Information				
Individual/Family Deductible	\$2,550/\$5,100		\$5,500/\$11,000	
Individual/Family OOP Limit	\$7,300/\$14,600 (incl ded)		\$6,550/\$13,100 (incl ded)	
Co-Insurance	0%		50%	
Office Visits				
Primary Care	No charge visits 1-3; \$40 after ded visits 4+		50% after ded	
Specialist	\$60 after ded		50% after ded	
Inpatient Services				
Inpatient Hospital	\$2,000/admit after ded; pre-auth req		50% after ded; pre-auth req	
Mental Health Inpatient	\$2,000/admit after ded; pre-auth req		50% after ded; pre-auth req	
Outpatient Services				
Outpatient Facility	\$200 after ded; pre-auth req		50% after ded; pre-auth req	
Lab/X-Ray	Lab-PCP-\$40 ded waived; SP-\$60 ded waived; X-ray-PCP-\$40 after ded; SP-\$60 after ded		50% after ded	
Mental Health Outpatient	\$40 after ded		50% after ded	
Emergency Care				
Emergency Room	\$500 (waived if admitted) after ded		50% after ded	
Urgent Care	\$75 ded waived		50% after ded	
Single	1 x \$687.19		1 x \$591.59	
EE with Spouse	0 x \$1,374.39		0 x \$1,183.18	
EE with Child(ren)	0 x \$1,168.24		0 x \$1,005.70	
Family	1 x \$1,958.50		1 x \$1,686.04	
Monthly Cost	2 \$2,645.69		2 \$2,277.63	
Annual Cost	\$31,748.28		\$27,331.56	

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