

	Emblem Prime EmblemHealth Platinum PPO Non-Gated (PPO) (UCR=80fh%)		Emblem Prime EmblemHealth Platinum Premier Non-Gated-P (HMO) (UCR=N/A)		Emblem Prime EmblemHealth Platinum Value Non-Gated-P (HMOc) (UCR=N/A)	
	In-Network	Out-Network	In-Network		In-Network	Out-Network
Prescription Drugs						
Drug Card	0/30/80		0/30/65		0/30/60 IntDed T2-3	
Cost Share Information						
Individual/Family Deductible	N/A	\$2,600/\$5,200	N/A		\$250/\$500	
Individual/Family OOP Limit	\$2,500/\$5,000	\$5,000/\$10,000 (incl ded)	\$2,000/\$4,000		\$2,500/\$5,000 (incl ded)	
Co-Insurance	0%	30%	20%		20%	
Office Visits						
Primary Care	No charge visits 1-3; \$15 visits 4+	30% after ded	No charge visits 1-3; \$15 visits 4+		No charge visits 1-3; \$15 ded waived visits 4+	
Specialist	\$35	30% after ded	\$35		\$35 ded waived	
Maternity Prenatal/Postnatal Care	No charge	30% after ded	No charge		No charge	
Chiropractic Care	\$35	30% after ded	\$35		\$35 ded waived	
Inpatient Services						
Inpatient Hospital	20%; pre-auth req	30% after ded; pre-auth req	20%; pre-auth req		20% after ded; pre-auth req	
Mental Health Inpatient	20%; pre-auth req	30% after ded; pre-auth req	20%; pre-auth req		20% after ded; pre-auth req	
Substance Abuse Inpatient	20%; pre-auth req	30% after ded; pre-auth req	20%; pre-auth req		20% after ded; pre-auth req	
Outpatient Services						
Outpatient Facility	\$150; pre-auth req	30% after ded; pre-auth req	\$250; pre-auth req		\$250 after ded; pre-auth req	
Lab/X-Ray	\$15/\$35 (PCP/SP); pre-auth req	30% after ded; pre-auth req	\$15/\$35 (PCP/SP); pre-auth req		Lab-\$15/\$35 ded waived (PCP/SP)/X-ray-\$15/\$35 after ded (PCP/SP); pre-auth req	
Advanced Radiology	\$35; pre-auth req	30% after ded; pre-auth req	\$35; pre-auth req		\$35 after ded ; pre-auth req	
Mental Health Outpatient	\$15	30% after ded	\$15		\$15 ded waived	
Substance Abuse Outpatient	\$15	30% after ded	\$15		\$15 ded waived	
Emergency Care						
Emergency Room	\$750 (waived if admitted)	\$750 (waived if admitted) ded waived	\$400 (waived if admitted)		\$400 (waived if admitted) after ded	
Ambulance	20%	20% ded waived	\$250		\$250 after ded	
Urgent Care	\$75	30% after ded	\$75		\$75 ded waived	
Recovery/Special Needs						
Home Health Care	\$35; 40 visits/plan yr; pre-auth req	30% after ded; 40 visits/plan yr; pre-auth req	\$35; 40 visits/plan yr; pre-auth req		\$35 after ded; 40 visits/plan yr; pre-auth req	
Skilled Nursing	20%; 200 days/plan yr; pre-auth req	Not covered	20%; 200 days/plan yr; pre-auth req		20% after ded; 200 days/plan yr; pre-auth req	
Durable Medical Equipment	10%; pre-auth req	Not covered	10%; pre-auth req		10% after ded; pre-auth req	
Single	2 x	\$1,227.61	2 x	\$1,217.89	2 x	\$1,183.93
EE with Spouse	0 x	\$2,455.22	0 x	\$2,435.78	0 x	\$2,367.86
EE with Child(ren)	0 x	\$2,086.93	0 x	\$2,070.41	0 x	\$2,012.68
Family	0 x	\$3,498.69	0 x	\$3,470.98	0 x	\$3,374.20
Monthly Cost	2	\$2,455.22	2	\$2,435.78	2	\$2,367.86
Annual Cost		\$29,462.64		\$29,229.36		\$28,414.32

	Emblem Prime EmblemHealth Gold PPO Non-Gated (PPOc) (UCR=80fh%)		Emblem Prime EmblemHealth Gold Premier Non-Gated-P (HMOc) (UCR=N/A)		Emblem Prime EmblemHealth Gold Virtual EPO Non-Gated-P (EPOc) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs						
Drug Card	0/35/100		0/40/80		0/40/80 IntDed T2-3	
Cost Share Information						
Individual/Family Deductible	\$1,300/\$2,600	\$3,500/\$7,000	\$450/\$900		\$500/\$1,000	
Individual/Family OOP Limit	\$5,500/\$11,000 (incl ded)	\$7,500/\$15,000 (incl ded)	\$5,600/\$11,200 (incl ded)		\$7,800/\$15,600 (incl ded)	
Co-Insurance	30%	40%	30%		30%	
Office Visits						
Primary Care	No charge visits 1-3; \$25 ded waived visits 4+	40% after ded	No charge visits 1-3; \$25 ded waived visits 4+		\$40 ded waived (No charge preferred provider)	
Specialist	\$40 ded waived	40% after ded	\$40 ded waived		\$60 ded waived	
Maternity Prenatal/Postnatal Care	No charge	40% after ded	No charge		No charge	
Chiropractic Care	\$40 ded waived	40% after ded	\$40 ded waived		\$60 ded waived	
Inpatient Services						
Inpatient Hospital	30% after ded; pre-auth req	40% after ded; pre-auth req	30% after ded; pre-auth req		30% after ded; pre-auth req	
Mental Health Inpatient	30% after ded; pre-auth req	40% after ded; pre-auth req	30% after ded; pre-auth req		30% after ded; pre-auth req	
Substance Abuse Inpatient	30% after ded; pre-auth req	40% after ded; pre-auth req	30% after ded; pre-auth req		30% after ded; pre-auth req	
Outpatient Services						
Outpatient Facility	\$200 after ded; pre-auth req	40% after ded; pre-auth req	\$350 after ded; pre-auth req		\$350 after ded; pre-auth req	
Lab/X-Ray	\$25/\$40 after ded (PCP/SP); pre-auth req	40% after ded; pre-auth req	Lab-\$25/\$40 ded waived (PCP/SP)/X-ray-\$25/\$40 after ded (PCP/SP); pre-auth req		Lab-\$0/\$60 ded waived (PCP/SP)/X-ray-\$40/\$60 after ded (PCP/SP); pre-auth req	
Advanced Radiology	\$40 after ded; pre-auth req	40% after ded; pre-auth req	\$40 after ded; pre-auth req		\$60 after ded; pre-auth req	
Mental Health Outpatient	\$25 ded waived	40% after ded	\$25 ded waived		\$40 ded waived	
Substance Abuse Outpatient	\$25 ded waived	40% after ded	\$25 ded waived		\$40 ded waived	
Emergency Care						
Emergency Room	\$1,000 (waived if admitted) after ded	\$1,000 (waived if admitted) after ded	\$800 (waived if admitted) after ded		40% after ded	
Ambulance	30% after ded	30% after ded	\$350 after ded		\$350 after ded	
Urgent Care	\$75 ded waived	40% after ded	\$75 ded waived		\$75 ded waived	
Recovery/Special Needs						
Home Health Care	\$40 after ded; 40 visits/plan yr; pre-auth req	40% after ded; 40 visits/plan yr; pre-auth req	\$40 after ded; 40 visits/plan yr; pre-auth req		\$60 after ded; 40 visits/plan yr; pre-auth req	
Skilled Nursing	30% after ded; 200 days/plan yr; pre-auth req	Not covered	30% after ded; 200 days/plan yr; pre-auth req		30% after ded; 200 days/plan yr; pre-auth req	
Durable Medical Equipment	20% after ded; pre-auth req	Not covered	20% after ded; pre-auth req		20% after ded; pre-auth req	
Single	2 x \$993.05		2 x \$991.94		2 x \$938.94	
EE with Spouse	0 x \$1,986.10		0 x \$1,983.88		0 x \$1,877.87	
EE with Child(ren)	0 x \$1,688.19		0 x \$1,686.30		0 x \$1,596.19	
Family	0 x \$2,830.19		0 x \$2,827.04		0 x \$2,675.96	
Monthly Cost	2 \$1,986.10		2 \$1,983.88		2 \$1,877.88	
Annual Cost	\$23,833.20		\$23,806.56		\$22,534.56	

	Emblem Prime EmblemHealth Gold Value Non-Gated-P (HMOc) (UCR=N/A)		Emblem Prime EmblemHealth Silver Premier Non-Gated-P (HMOc) (UCR=N/A)		Emblem Prime EmblemHealth Silver Value Non-Gated-P (HMOc) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs						
Drug Card	0/40/80 IntDed T2-3		0/40/80		0%/0%/0% IntDed T2-3	
Cost Share Information						
Individual/Family Deductible	\$2,300/\$4,600		\$3,600/\$7,200		\$6,700/\$13,400	
Individual/Family OOP Limit	\$5,300/\$10,600 (incl ded)		\$7,800/\$15,600 (incl ded)		\$6,700/\$13,400 (incl ded)	
Co-Insurance	30%		40%		0%	
Office Visits						
Primary Care	No charge visits 1-3; \$25 ded waived visits 4+		No charge visits 1-3; \$35 ded waived visits 4+		No charge visits 1-3; \$10 ded waived visits 4+	
Specialist	\$40 ded waived		\$65 ded waived		\$55 ded waived	
Maternity Prenatal/Postnatal Care	No charge		No charge		No charge	
Chiropractic Care	\$40 ded waived		\$65 ded waived		\$55 ded waived	
Inpatient Services						
Inpatient Hospital	30% after ded; pre-auth req		40% after ded; pre-auth req		0% after ded; pre-auth req	
Mental Health Inpatient	30% after ded; pre-auth req		40% after ded; pre-auth req		0% after ded; pre-auth req	
Substance Abuse Inpatient	30% after ded; pre-auth req		40% after ded; pre-auth req		0% after ded; pre-auth req	
Outpatient Services						
Outpatient Facility	\$350 after ded; pre-auth req		\$350 after ded; pre-auth req		0% after ded; pre-auth req	
Lab/X-Ray	Lab-\$25/\$40 ded waived (PCP/SP)/X-ray-\$25/\$40 after ded (PCP/SP); pre-auth req		Lab-\$35/\$65 ded waived (PCP/SP)/X-ray-\$35/\$65 after ded (PCP/SP); pre-auth req		Lab-\$10/\$55 ded waived (PCP/SP); X-ray-0% after ded; pre-auth req	
Advanced Radiology	\$40 after ded; pre-auth req		\$65 after ded; pre-auth req		0% after ded; pre-auth req	
Mental Health Outpatient	\$25 ded waived		\$35 ded waived		\$10 ded waived	
Substance Abuse Outpatient	\$25 ded waived		\$35 ded waived		\$10 ded waived	
Emergency Care						
Emergency Room	\$800 (waived if admitted) after ded		40% after ded		0% after ded	
Ambulance	\$350 after ded		\$350 after ded		0% after ded	
Urgent Care	\$75 ded waived		\$75 ded waived		\$75 ded waived	
Recovery/Special Needs						
Home Health Care	\$50 after ded; 40 visits/plan yr; pre-auth req		\$65 after ded; 40 visits/plan yr; pre-auth req		0% after ded; 40 visits/plan yr; pre-auth req	
Skilled Nursing	30% after ded; 200 days/plan yr; pre-auth req		40% after ded; 200 days/plan yr; pre-auth req		0% after ded; 200 days/plan yr; pre-auth req	
Durable Medical Equipment	20% after ded; pre-auth req		30% after ded; pre-auth req		0% after ded; pre-auth req	
Single	2 x	\$937.24	2 x	\$853.12	2 x	\$825.16
EE with Spouse	0 x	\$1,874.47	0 x	\$1,706.24	0 x	\$1,650.33
EE with Child(ren)	0 x	\$1,593.30	0 x	\$1,450.30	0 x	\$1,402.78
Family	0 x	\$2,671.12	0 x	\$2,431.39	0 x	\$2,351.71
Monthly Cost	2	\$1,874.48	2	\$1,706.24	2	\$1,650.32
Annual Cost		\$22,493.76		\$20,474.88		\$19,803.84

	Emblem Prime EmblemHealth Silver Plus HSA Non-Gated (HSA) (UCR=N/A)		Emblem Prime EmblemHealth Bronze Premier Non-Gated-P (HMOc) (UCR=N/A)		Emblem Prime EmblemHealth Bronze Plus HSA Non-Gated (HSA) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Prescription Drugs						
Drug Card	15/45/80 IntDed		50/50%/50% IntDed T2-3		15/65/80 IntDed	
Cost Share Information						
Individual/Family Deductible	\$3,000/\$6,000		\$5,300/\$10,600		\$6,300/\$12,600	
Individual/Family OOP Limit	\$6,000/\$12,000 (incl ded)		\$8,450/\$16,900 (incl ded)		\$6,900/\$13,800 (incl ded)	
Co-Insurance	40%		50%		50%	
Office Visits						
Primary Care	\$30 after ded		No charge visits 1-3; 50% after ded visits 4+		50% after ded	
Specialist	\$50 after ded		50% after ded		50% after ded	
Maternity Prenatal/Postnatal Care	No charge		No charge		No charge	
Chiropractic Care	\$50 after ded		50% after ded		50% after ded	
Inpatient Services						
Inpatient Hospital	40% after ded; pre-auth req		50% after ded; pre-auth req		50% after ded; pre-auth req	
Mental Health Inpatient	40% after ded; pre-auth req		50% after ded; pre-auth req		50% after ded; pre-auth req	
Substance Abuse Inpatient	40% after ded; pre-auth req		50% after ded; pre-auth req		50% after ded; pre-auth req	
Outpatient Services						
Outpatient Facility	\$350 after ded; pre-auth req		50% after ded; pre-auth req		50% after ded; pre-auth req	
Lab/X-Ray	\$30/\$50 after ded (PCP/SP); pre-auth req		50% after ded; pre-auth req		50% after ded; pre-auth req	
Advanced Radiology	\$50 after ded; pre-auth req		50% after ded; pre-auth req		50% after ded; pre-auth req	
Mental Health Outpatient	\$30 after ded		50% after ded		50% after ded	
Substance Abuse Outpatient	\$30 after ded		50% after ded		50% after ded	
Emergency Care						
Emergency Room	40% after ded		50% after ded		50% after ded	
Ambulance	\$350 after ded		50% after ded		50% after ded	
Urgent Care	\$100 after ded		\$75 ded waived		\$100 after ded	
Recovery/Special Needs						
Home Health Care	\$50 after ded; 40 visits/plan yr; pre-auth req		50% after ded; 40 visits/plan yr; pre-auth req		50% after ded; 40 visits/plan yr; pre-auth req	
Skilled Nursing	40% after ded; 200 days/plan yr; pre-auth req		50% after ded; 200 days/plan yr; pre-auth req		50% after ded; 200 days/plan yr; pre-auth req	
Durable Medical Equipment	30% after ded; pre-auth req		50% after ded; pre-auth req		50% after ded; pre-auth req	
Single	2 x \$817.81		2 x \$738.02		2 x \$729.85	
EE with Spouse	0 x \$1,635.62		0 x \$1,476.03		0 x \$1,459.70	
EE with Child(ren)	0 x \$1,390.28		0 x \$1,254.63		0 x \$1,240.75	
Family	0 x \$2,330.76		0 x \$2,103.35		0 x \$2,080.07	
Monthly Cost	2 \$1,635.62		2 \$1,476.04		2 \$1,459.70	
Annual Cost	\$19,627.44		\$17,712.48		\$17,516.40	

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: Emblem 2021 2nd qtr Prime NY City
New York County, NY 10001

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Health Plan Comparison Report (3P)

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	Emblem Prime EmblemHealth Bronze Value Non-Gated-P (HMOc) (UCR=N/A)	
	In-Network	Out-Network
Prescription Drugs		
Drug Card	35/0%/0% IntDed T2-3	
Cost Share Information		
Individual/Family Deductible	\$8,550/\$17,100	
Individual/Family OOP Limit	\$8,550/\$17,100 (incl ded)	
Co-Insurance	0%	
Office Visits		
Primary Care	No charge visits 1-3; 0% after ded visits 4+	
Specialist	0% after ded	
Maternity Prenatal/Postnatal Care	No charge	
Chiropractic Care	0% after ded	
Inpatient Services		
Inpatient Hospital	0% after ded; pre-auth req	
Mental Health Inpatient	0% after ded; pre-auth req	
Substance Abuse Inpatient	0% after ded; pre-auth req	
Outpatient Services		
Outpatient Facility	0% after ded; pre-auth req	
Lab/X-Ray	0% after ded; pre-auth req	
Advanced Radiology	0% after ded; pre-auth req	
Mental Health Outpatient	0% after ded	
Substance Abuse Outpatient	0% after ded	
Emergency Care		
Emergency Room	0% after ded	
Ambulance	0% after ded	
Urgent Care	\$75 ded waived	
Recovery/Special Needs		
Home Health Care	0% after ded; 40 visits/plan yr; pre-auth req	
Skilled Nursing	0% after ded; 200 days/plan yr; pre-auth req	
Durable Medical Equipment	0% after ded; pre-auth req	
Single	2 x	\$700.35
EE with Spouse	0 x	\$1,400.69
EE with Child(ren)	0 x	\$1,190.59
Family	0 x	\$1,995.98
Monthly Cost	2	\$1,400.70
Annual Cost		\$16,808.40

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