Prepared For: Emblem 2021 2nd qtr Selectcare NY City
New York County, NY 10001
Prepared By: Clifford Grekin Inc. - (631)963-6020

Health Plan Comparison Report (2P)
Effective Date: 04/01/2021 Prepared On: 01/14/2021
Report ID: 38186840 SIC: 0000

	Emblem Select Care EmblemHealth Platinum Premier Non-Gated-S (HMO) (UCR=N/A)	**Emblem Select Care EmblemHealth Platinum Value Non-Gated-S (HMOc) (UCR=N/A)**	
	In-Network	**In-Network**	**Out-Network**
Prescription Drugs			
Drug Card	0/30/65	0/30/60 IntDed T2-3	
Cost Share Information			
Individual/Family Deductible	N/A	$250/$500	
Individual/Family OOP Limit	$2,000/$4,000	$2,500/$5,000 (incl ded)	
Co-Insurance	20%	20%	
Office Visits			
Primary Care	No charge visits 1-3; $15 visits 4+	No charge visits 1-3; $15 ded waived visits 4+	
Specialist	$35	$35 ded waived	
Maternity Prenatal/Postnatal Care	No charge	No charge	
Chiropractic Care	$35	$35 ded waived	
Inpatient Services			
Inpatient Hospital	20%; pre-auth req	20% after ded; pre-auth req	
Mental Health Inpatient	20%; pre-auth req	20% after ded; pre-auth req	
Substance Abuse Inpatient	20%; pre-auth req	20% after ded; pre-auth req	
Outpatient Services			
Outpatient Facility	$250; pre-auth req	$250 after ded; pre-auth req	
Lab/X-Ray	$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	$35 after ded ; pre-auth req	
Mental Health Outpatient	$15	$15 ded waived	
Substance Abuse Outpatient	$15	$15 ded waived	
Emergency Care			
Emergency Room	$400 (waived if admitted)	$400 (waived if admitted) after ded	
Ambulance	$250	$250 after ded	
Urgent Care	$75	$75 ded waived	
Recovery/Special Needs			
Home Health Care	$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	20% after ded; 200 days/plan yr; pre-auth req	
Durable Medical Equipment	10%; pre-auth req	10% after ded; pre-auth req	
Single	2 x $1,116.29	2 x $1,085.19	
EE with Spouse	0 x $2,232.58	0 x $2,170.38	
EE with Child(ren)	0 x $1,897.69	0 x $1,844.83	
Family	0 x $3,181.43	0 x $3,092.79	
Monthly Cost	2 $2,232.58	2 $2,170.38	
Annual Cost	$26,790.96	$26,044.56	

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	Emblem Select Care EmblemHealth Gold Premier Non-Gated-S (HMOc) (UCR=N/A)		**Emblem Select Care EmblemHealth Gold Value Non-Gated-S (HMOc) (UCR=N/A)**	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs				
Drug Card	0/40/80		0/40/80 IntDed T2-3	
Cost Share Information				
Individual/Family Deductible	$450/$900		$2,300/$4,600	
Individual/Family OOP Limit	$5,600/$11,200 (incl ded)		$5,300/$10,600 (incl ded)	
Co-Insurance	30%		30%	
Office Visits				
Primary Care	No charge visits 1-3; $25 ded waived visits 4+		No charge visits 1-3; $25 ded waived visits 4+	
Specialist	$40 ded waived		$40 ded waived	
Maternity Prenatal/Postnatal Care	No charge		No charge	
Chiropractic Care	$40 ded waived		$40 ded waived	
Inpatient Services				
Inpatient Hospital	30% after ded; pre-auth req		30% after ded; pre-auth req	
Mental Health Inpatient	30% after ded; pre-auth req		30% after ded; pre-auth req	
Substance Abuse Inpatient	30% after ded; pre-auth req		30% after ded; pre-auth req	
Outpatient Services				
Outpatient Facility	$350 after ded; pre-auth req		$350 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-$25/$40 ded waived (PCP/SP)/X-ray-$25/$40 after ded (PCP/SP); pre-auth req	
Advanced Radiology	$40 after ded; pre-auth req		$40 after ded; pre-auth req	
Mental Health Outpatient	$25 ded waived		$25 ded waived	
Substance Abuse Outpatient	$25 ded waived		$25 ded waived	
Emergency Care				
Emergency Room	$800 (waived if admitted) after ded		$800 (waived if admitted) after ded	
Ambulance	$350 after ded		$350 after ded	
Urgent Care	$75 ded waived		$75 ded waived	
Recovery/Special Needs				
Home Health Care	$40 after ded; 40 visits/plan yr; pre-auth req		$50 after ded; 40 visits/plan yr; pre-auth req	
Skilled Nursing	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		20% after ded; pre-auth req	
Single	2 x $909.38		2 x $859.28	
EE with Spouse	0 x $1,818.76		0 x $1,718.57	
EE with Child(ren)	0 x $1,545.95		0 x $1,460.78	
Family	0 x $2,591.73		0 x $2,448.96	
Monthly Cost	2 $1,818.76		2 $1,718.56	
Annual Cost	$21,825.12		$20,622.72	

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	Emblem Select Care EmblemHealth Silver Premier Non-Gated-S (HMOc) (UCR=N/A)		**Emblem Select Care EmblemHealth Silver Value Non-Gated-S (HMOc) (UCR=N/A)**	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs				
Drug Card	0/40/80		0%/0%/0% IntDed T2-3	
Cost Share Information				
Individual/Family Deductible	$3,600/$7,200		$6,700/$13,400	
Individual/Family OOP Limit	$7,800/$15,600 (incl ded)		$6,700/$13,400 (incl ded)	
Co-Insurance	40%		0%	
Office Visits				
Primary Care	No charge visits 1-3; $35 ded waived visits 4+		No charge visits 1-3; $10 ded waived visits 4+	
Specialist	$65 ded waived		$55 ded waived	
Maternity Prenatal/Postnatal Care	No charge		No charge	
Chiropractic Care	$65 ded waived		$55 ded waived	
Inpatient Services				
Inpatient Hospital	40% after ded; pre-auth req		0% after ded; pre-auth req	
Mental Health Inpatient	40% after ded; pre-auth req		0% after ded; pre-auth req	
Substance Abuse Inpatient	40% after ded; pre-auth req		0% after ded; pre-auth req	
Outpatient Services				
Outpatient Facility	$350 after ded; pre-auth req		0% after ded; pre-auth req	
Lab/X-Ray	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	$65 after ded; pre-auth req		0% after ded; pre-auth req	
Mental Health Outpatient	$35 ded waived		$10 ded waived	
Substance Abuse Outpatient	$35 ded waived		$10 ded waived	
Emergency Care				
Emergency Room	40% after ded		0% after ded	
Ambulance	$350 after ded		0% after ded	
Urgent Care	$75 ded waived		$75 ded waived	
Recovery/Special Needs				
Home Health Care	$65 after ded; 40 visits/plan yr; pre-auth req		0% after ded; 40 visits/plan yr; pre-auth req	
Skilled Nursing	40% after ded; 200 days/plan yr; pre-auth req		0% after ded; 200 days/plan yr; pre-auth req	
Durable Medical Equipment	30% after ded; pre-auth req		0% after ded; pre-auth req	
Single	2 x $782.54		2 x $756.93	
EE with Spouse	0 x $1,565.08		0 x $1,513.87	
EE with Child(ren)	0 x $1,330.32		0 x $1,286.79	
Family	0 x $2,230.24		0 x $2,157.26	
Monthly Cost	2 $1,565.08		2 $1,513.86	
Annual Cost	$18,780.96		$18,166.32	

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	Emblem Select Care EmblemHealth Bronze Premier Non-Gated-S (HMOc) (UCR=N/A)		**Emblem Select Care EmblemHealth Bronze Value Non-Gated-S (HMOc) (UCR=N/A)**	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs				
Drug Card	50/50%/50% IntDed T2-3		35/0%/0% IntDed T2-3	
Cost Share Information				
Individual/Family Deductible	$5,300/$10,600		$8,550/$17,100	
Individual/Family OOP Limit	$8,450/$16,900 (incl ded)		$8,550/$17,100 (incl ded)	
Co-Insurance	50%		0%	
Office Visits				
Primary Care	No charge visits 1-3; 50% after ded visits 4+		No charge visits 1-3; 0% after ded visits 4+	
Specialist	50% after ded		0% after ded	
Maternity Prenatal/Postnatal Care	No charge		No charge	
Chiropractic Care	50% after ded		0% after ded	
Inpatient Services				
Inpatient Hospital	50% after ded; pre-auth req		0% after ded; pre-auth req	
Mental Health Inpatient	50% after ded; pre-auth req		0% after ded; pre-auth req	
Substance Abuse Inpatient	50% after ded; pre-auth req		0% after ded; pre-auth req	
Outpatient Services				
Outpatient Facility	50% after ded; pre-auth req		0% after ded; pre-auth req	
Lab/X-Ray	50% after ded; pre-auth req		0% after ded; pre-auth req	
Advanced Radiology	50% after ded; pre-auth req		0% after ded; pre-auth req	
Mental Health Outpatient	50% after ded		0% after ded	
Substance Abuse Outpatient	50% after ded		0% after ded	
Emergency Care				
Emergency Room	50% after ded		0% after ded	
Ambulance	50% after ded		0% after ded	
Urgent Care	$75 ded waived		$75 ded waived	
Recovery/Special Needs				
Home Health Care	50% after ded; 40 visits/plan yr; pre-auth req		0% after ded; 40 visits/plan yr; pre-auth req	
Skilled Nursing	50% after ded; 200 days/plan yr; pre-auth req		0% after ded; 200 days/plan yr; pre-auth req	
Durable Medical Equipment	50% after ded; pre-auth req		0% after ded; pre-auth req	
Single	2 x $677.14		2 x $642.64	
EE with Spouse	0 x $1,354.28		0 x $1,285.28	
EE with Child(ren)	0 x $1,151.13		0 x $1,092.49	
Family	0 x $1,929.85		0 x $1,831.54	
Monthly Cost	2 $1,354.28		2 $1,285.28	
Annual Cost	$16,251.36		$15,423.36	

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