

	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)		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		In-Network		In-Network		In-Network	
Prescription Drugs								
Drug Card	0/30/65		0/30/65 IntDed T2-3		0/40/80		0/40/80 IntDed T2-3	
Cost Share Information								
Individual/Family Deductible	N/A		\$250/\$500		\$450/\$900		\$2,500/\$5,000	
Individual/Family OOP Limit	\$2,000/\$4,000		\$2,500/\$5,000 (incl ded)		\$6,000/\$12,000 (incl ded)		\$7,000/\$14,000 (incl ded)	
Co-Insurance	20%		20%		30%		30%	
Office Visits								
Primary Care	No charge visits 1-3; \$15 visits 4+		No charge visits 1-3; \$15 ded waived visits 4+		No charge visits 1-3; \$25 ded waived visits 4+		No charge visits 1-3; \$25 ded waived visits 4+	
Specialist	\$35		\$35 ded waived		\$40 ded waived		\$40 ded waived	
Inpatient Services								
Inpatient Hospital	20%; pre-auth req		20% after ded; pre-auth req		30% after ded; pre-auth req		30% after ded; pre-auth req	
Mental Health Inpatient	20%; pre-auth req		20% after ded; pre-auth req		30% after ded; pre-auth req		30% after ded; pre-auth req	
Outpatient Services								
Outpatient Facility	\$250; pre-auth req		\$250 after ded; pre-auth req		\$350 after ded; pre-auth req		\$350 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		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	
Mental Health Outpatient	No charge visits 1-3; \$15 visits 4+		No charge visits 1-3; \$15 ded waived visits 4+		No charge visits 1-3; \$25 ded waived visits 4+		No charge visits 1-3; \$25 ded waived visits 4+	
Emergency Care								
Emergency Room	\$400 (waived if admitted)		\$400 (waived if admitted) after ded		\$800 (waived if admitted) after ded		\$800 (waived if admitted) after ded	
Urgent Care	\$75		\$75 ded waived		\$75 ded waived		\$75 ded waived	
Single	2 x	\$1,219.76	2 x	\$1,185.66	2 x	\$992.98	2 x	\$938.07
EE with Spouse	0 x	\$2,439.51	0 x	\$2,371.33	0 x	\$1,985.95	0 x	\$1,876.15
EE with Child(ren)	0 x	\$2,073.59	0 x	\$2,015.63	0 x	\$1,688.06	0 x	\$1,594.73
Family	0 x	\$3,476.31	0 x	\$3,379.14	0 x	\$2,829.98	0 x	\$2,673.51
Monthly Cost	2	\$2,439.52	2	\$2,371.32	2	\$1,985.96	2	\$1,876.14
Annual Cost		\$29,274.24		\$28,455.84		\$23,831.52		\$22,513.68

	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)		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		In-Network		In-Network		In-Network	
Prescription Drugs								
Drug Card	0/40/80		0%/0%/0% IntDed T2-3		50/50%/50% IntDed T2-3		35/0%/0% IntDed T2-3	
Cost Share Information								
Individual/Family Deductible	\$3,800/\$7,600		\$7,000/\$14,000		\$5,500/\$11,000		\$8,550/\$17,100	
Individual/Family OOP Limit	\$8,000/\$16,000 (incl ded)		\$7,000/\$14,000 (incl ded)		\$8,700/\$17,400 (incl ded)		\$8,550/\$17,100 (incl ded)	
Co-Insurance	40%		0%		50%		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+		No charge visits 1-3; 50% after ded visits 4+		No charge visits 1-3; 0% after ded visits 4+	
Specialist	\$65 ded waived		\$55 ded waived		50% after ded		0% after ded	
Inpatient Services								
Inpatient Hospital	40% after ded; pre-auth req		0% after ded; pre-auth req		50% 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		50% 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		50% 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		50% after ded; pre-auth req		0% after ded; pre-auth req	
Mental Health Outpatient	No charge visits 1-3; \$35 ded waived visits 4+		No charge visits 1-3; \$10 ded waived visits 4+		No charge visits 1-3; 50% after ded visits 4+		No charge visits 1-3; 0% after ded visits 4+	
Emergency Care								
Emergency Room	40% after ded		0% after ded		50% after ded		0% after ded	
Urgent Care	\$75 ded waived		\$75 ded waived		\$75 ded waived		\$75 ded waived	
Single	2 x	\$850.06	2 x	\$821.99	2 x	\$734.54	2 x	\$696.73
EE with Spouse	0 x	\$1,700.12	0 x	\$1,643.99	0 x	\$1,469.08	0 x	\$1,393.46
EE with Child(ren)	0 x	\$1,445.10	0 x	\$1,397.39	0 x	\$1,248.72	0 x	\$1,184.44
Family	0 x	\$2,422.67	0 x	\$2,342.69	0 x	\$2,093.44	0 x	\$1,985.67
Monthly Cost	2	\$1,700.12	2	\$1,643.98	2	\$1,469.08	2	\$1,393.46
Annual Cost		\$20,401.44		\$19,727.76		\$17,628.96		\$16,721.52

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