Prepared For: Emblem 2022 4th qtr Selectcare New York City

New York County, NY 10001

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

Health Plan Comparison Report (4L)

Effective Date: 10/01/2022 Prepared On: 07/19/2022

Report ID: 38691221

SIC: 0000

	Emblem Select Care EmblemHealth Platinum Premier Nor (HMO) (UCR=N/A)	Emblem Select Care -Gated-S EmblemHealth Platinum Value Non-Gated- (HMOc) (UCR=N/A)	Emblem Select Care -S 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 Individual/Family OOP Limit	N/A \$2,000/\$4,000	\$250/\$500 \$2,500/\$5,000 (incl ded)	\$450/\$900 \$6,000/\$12,000 (incl ded)	\$2,500/\$5,000 \$7,000/\$14,000 (incl ded)
Co-Insurance Office Visits	20%	20%	30%	30%
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 Inpatient Services	\$35	\$35 ded waived	\$40 ded waived	\$40 ded waived
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 Lab/X-Ray	\$250; pre-auth req \$15/\$35 (PCP/SP); pre-auth req	\$250 after ded; pre-auth req Lab-\$15/\$35 ded waived (PCP/SP)/X-ray-\$15/\$35 after ded (PCP/SP); pre-auth req	\$350 after ded; pre-auth req Lab-\$25/\$40 ded waived (PCP/SP)/X-ray-\$25/\$40 after ded (PCP/SP); pre-auth req	\$350 after ded; 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 \$1,274.01	2 x \$1,238.40	2 x \$1,037.16	2 x \$979.80
EE with Spouse	0 x \$2,548.03	0 x \$2,476.82	0 x \$2,074.29	0 x \$1,959.61
EE with Child(ren)	0 x \$2,165.83	0 x \$2,105.29	0 x \$1,763.15	0 x \$1,665.67
Family	0 x \$3,630.95	0 x \$3,529.46	0 x \$2,955.87	0 x \$2,792.44
Monthly Cost Annual Cost	2 \$2,548.02 \$30,576.24	2 \$2,476.80 \$29,721.60	2 \$2,074.32 \$24,891.84	2 \$1,959.60 \$23,515.20

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

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Health Plan Comparison Report (4L)

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repared By: Cliffor	d Grekin Inc (631)963-6020		Report ID: 386912	
	Emblem Select Care EmblemHealth Silver Premier No (HMOc) (UCR=N/A)	Emblem Select Care n-Gated-S EmblemHealth Silver Value Non-Gated-S (HM0 (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				
ndividual/Family Deductible ndividual/Family OOP Limit	\$3,800/\$7,600 \$8,000/\$16,000 (incl ded)	\$7,000/\$14,000 \$7,000/\$14,000 (incl ded)	\$5,500/\$11,000 \$8,700/\$17,400 (incl ded)	\$8,550/\$17,100 \$8,550/\$17,100 (incl ded)
Co-Insurance Office Visits	40%	0%	50%	0%
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
npatient Services				
npatient 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
Nental 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
Dutpatient 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
ab/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
Iental 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
Irgent Care	\$75 ded waived	\$75 ded waived	\$75 ded waived	\$75 ded waived
Single	2 x \$887.87	2 x \$858.55	2 x \$767.22	2 x \$727.73
E with Spouse	0 x \$1,775.75	0 x \$1,717.12	0 x \$1,534.43	0 x \$1,455.45
EE with Child(ren)	0 x \$1,509.38	0 x \$1,459.55	0 x \$1,304.27	0 x \$1,237.13
amily	0 x \$2,530.44	0 x \$2,446.90	0 x \$2,186.57	0 x \$2,074.00
Monthly Cost	2 \$1,775.74	2 \$1,717.10	2 \$1,534.44	2 \$1,455.46
Innual Cost	\$21,308.88	\$20,605.20	\$18,413.28	\$17,465.52

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