Service Station Dealers & Automotive Services of Greater NY

2024 Emblem Medical Election Form

EmblemHealth

Full Name _____ Station Name _____ Effective Date _____

Home Address _____ City _____ State _____ Zip _____

Email Address _____ Home Phone Number _____ Fax Number _____

Plan Features	Plat. Premier P		Gold Premier P		Silver Premier P		Bronze Premier P	Bronze Plus H.S.A
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
Deductible / Maximum Period	3/1 – 2/28		3/1 – 2/28		3/1 – 2/28		3/1 – 2/28	3/1 – 2/28
Network	Select Care		Select Care		Select Care		Select Care	Select Care
PCP Selection & Referrals	Not Required		Not Required		Not Required		Not Required	Not Required
Part D Creditable	Creditable		Creditable		Creditable		Creditable	Creditable
Plan Year Deductibles (Indiv / Family)	$100 / $200	$4,000/ $8,000	$500 / $1,000	$6,000/$12,000	$5,600 / $11,200	$8,000/$16,000	$7,100/$14,200	$7,400/$14,800
Deductible Type	Embedded		Embedded		Embedded		Embedded	Embedded
Plan Year Out-of-Pocket Max (Indiv / Family)	$2,300 / $4,600	$10,000/ $20,000	$7, 800 / $15,600	$12,000/ $24,000	$9,400 / $18,800	$18,000/ $36,000	$9,450/$18,900	$8,000/$16,000
Maximum Type	Embedded		Embedded		Embedded		Embedded	Embedded
Primary Care Visit	$0 first 3 Visits then $10 Copay	50% after Ded	$0 first 3 Visits then $25	50% after Ded	$0 first 3 Visits then $35 Copay	50% after Ded	$0 first 3 visits then 50% after Ded	50% after Ded
Specialist Visit	$35 Copay	50% after Ded	$50 Copay	50% after Ded	$75 Copay	50% after Ded	50% after Ded	50% after Ded
Telemedicine Services	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered	No Charge	$0 Copay after Ded
Diagnostic Lab in PCP Office	$10 Copay	50% after Ded	$25 Copay	50% after Ded	$35 Copay	50% after Ded	30% after Ded	30% after Ded
Diagnostic Lab in Specialist Office	$35 Copay	50% after Ded	$50 Copay	50% after Ded	$75 Copay	50% after Ded	50% after Ded	50% after Ded
X-Ray in PCP Office	$10 after Ded	50% after Ded	$25 after Ded	50% after Ded	$35 after Ded	50% after Ded	30% after Ded	30% after Ded
X-Ray in Specialist	$35 after Ded	50% after Ded	$50 after Ded	50% after Ded	$75 after Ded	50% after Ded	50% after Ded	50% after Ded
Hospital Outpatient Surgery	$250 after Ded	50% after Ded	$350 after Ded	50% after Ded	$450 after Ded	50% after Ded	50% after Ded	50% after Ded
Hospital/Maternity Inpatient Services,	20% after Ded	50% after Ded	30% after Ded	50% after Ded	40% after Ded	50% after Ded	50% after Ded	50% after Ded
Mental Health Office Visit	$0 first 3 Visits then $10 Copay	50% after Ded	$0 first 3 Visits then $25 Copay	50% after Ded	$0 first Visit then $35 Copay	50% after Ded	$0 first visit then 50% after Ded	50% after Ded
Ambulance Services	$250 after Ded		$350 after Ded		$450 after Ded		50% after Ded	50% after Ded
Emergency Room	20% after Ded		30% after Ded		40% after Ded		50% after Ded	50% after Ded
Urgent Care	$100 after Ded	50% after Ded	$100 after Ded	50% after Ded	$100 after Ded	50% after Ded	50% after Ded	$100 after Ded
Prescription Drug Coverage								
Rx Plan Year Deductible	$100 / $200	N/A	$150 / $300	N/A	$250/$500	N/A	Combined with Med, Tier 2 & 3	Combined with Medical, all tiers
Retail	$5 / $30 after Ded / $65 after Ded	N/A	$7 / $40 / $80	N/A	$20 / $40 / $100	N/A	$50 / 50% / 50% after Ded	$35 / $65 / $115 after Ded
Mail Order	$12.50 / $75 after Ded/ $162.50 after Ded	N/A	$17.50 / $100 / $200	N/A	$50 / $100 / $250	N/A	$125 / 50% / 50% after Ded	$87.50 / $162.50 / $287.50 after Ded
MONTHLY PREMIUM AND PLAN SELECTION								
Single	❑ **$1,596.02**		❑ **$1,272.88**		❑ **$1,088.08**		❑ **$946.58**	❑ **$959.67**
EE/Spouse	❑ **$3,109.04**		❑ **$2,462.76**		❑ **$2,093.16**		❑ **$1,810.16**	❑ **$1,836.34**
EE/Child(ren)	❑ **$2,655.13**		❑ **$2,105.80**		❑ **$1,791.64**		❑ **$1,551.09**	❑ **$1,573.34**
Family	❑ **$4,395.11**		❑ **$3,474.16**		❑ **$2,947.48**		❑ **$2,544.20**	❑ **$2,581.51**

- CVS/Target is NOT an EmblemHealth participating pharmacy.
- Please visit EmblemHealth at https://www.emblemhealth.com/Members to find in network providers.
- EmblemHealth transaction/enrollment form must be completed in addition to medical election form for any changes.

"By signing below, in order to avoid cancellation, I agree to pay all insurance premiums by the end of the billing month."

Signature _____ Date _____

Please return completed form via Secure Fax to:
(914) 962-0108. If you have any questions, please call (866) 573-4768 ext. 2481

www.emblemhealth.com