Prepared For: Emblem 2021 3rd qtr Millenium Nassau Suffolk

Nassau County, NY 11565

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

Health Plan Comparison Report (4L)

Effective Date: 07/01/2021

Prepared On: 04/20/2021

SIC: 0000

Report ID: 38287543

	Emblem Millennium EmblemHealth Platinum Premier Gated-M (HM (UCR=N/A)	Emblem Millennium O) EmblemHealth Platinum Value Gated-M (HMOc) (UCR=N/A)	Emblem Millennium EmblemHealth Gold Premier Gated-M (HMOc) (UCR=N/A)	Emblem Millennium EmblemHealth Gold Value Gated-M (HMOc) (UCR=N/A)
	In-Network	In-Network	In-Network	In-Network
Prescription Drugs				
Drug Card	0/30/65	0/30/60 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 \$5,600/\$11,200 (incl ded)	\$2,300/\$4,600 \$5,300/\$10,600 (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	\$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	\$15	\$15 ded waived	\$25 ded waived	\$25 ded waived
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 \$1,215.11	2 x \$1,181.18	2 x \$989.37	2 x \$934.70
EE with Spouse	0 x \$2,430.22	0 x \$2,362.38	0 x \$1,978.74	0 x \$1,869.42
EE with Child(ren)	0 x \$2,065.69	0 x \$2,008.02	0 x \$1,681.92	0 x \$1,589.00
Family	0 x \$3,463.08	0 x \$3,366.39	0 x \$2,819.70	0 x \$2,663.92
Monthly Cost	2 \$2,430.22	2 \$2,362.36	2 \$1,978.74	2 \$1,869.40
Annual Cost	\$29,162.64	\$28,348.32	\$23,744.88	\$22,432.80

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Prescription Drugs Drug Card O/40/80 IntD Cost Share Information Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Office Visits Primary Care \$40 ded wai charge prefiprovider) Specialist Inpatient Services Inpatient Hospital Mental Health Inpatient Outpatient Services Outpatient Facility \$350 after degree Lab/X-Ray \$450/\$60	400 6,400 (incl ded) aived (No ferred	\$3,600/\$7,200 \$7,800/\$15,600 (incl ded) 40% No charge visits 1-3; \$35 ded waived visits 4+ \$65 ded waived 40% after ded; pre-auth req 40% after ded; pre-auth req	## In-Network 0%/0%/0% IntDed T2-3	\$5,300/\$10,600 \$8,450/\$16,900 (incl ded) 50% No charge visits 1-3; 50% after ded visits 4+ 50% after ded; pre-auth req 50% after ded; pre-auth
Drug Card O/40/80 IntD Cost Share Information Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Office Visits Primary Care \$40 ded was charge prefe provider) Specialist Inpatient Services Inpatient Hospital Mental Health Inpatient Outpatient Services Outpatient Facility Lab/X-Ray Mental Health Outpatient \$40 ded was Inpatient Services Outpatient Services	400 6,400 (incl ded) aived (No ferred aived ded; pre-auth	\$3,600/\$7,200 \$7,800/\$15,600 (incl ded) 40% No charge visits 1-3; \$35 ded waived visits 4+ \$65 ded waived 40% after ded; pre-auth req 40% after ded; pre-auth	\$6,700/\$13,400 \$6,700/\$13,400 (incl ded) 0% No charge visits 1-3; \$10 ded waived visits 4+ \$55 ded waived 0% after ded; pre-auth req 0% after ded; pre-auth	\$5,300/\$10,600 \$8,450/\$16,900 (incl ded) 50% No charge visits 1-3; 50% after ded visits 4+ 50% after ded 50% after ded; pre-auth req 50% after ded; pre-auth
Cost Share Information Individual/Family Deductible Individual/Family OOP Limit \$8,200/\$16, \$16,200/\$16,200/\$16,200/\$16,200/\$16,200/\$16,200/\$16,20	400 6,400 (incl ded) aived (No ferred aived ded; pre-auth	\$3,600/\$7,200 \$7,800/\$15,600 (incl ded) 40% No charge visits 1-3; \$35 ded waived visits 4+ \$65 ded waived 40% after ded; pre-auth req 40% after ded; pre-auth	\$6,700/\$13,400 \$6,700/\$13,400 (incl ded) 0% No charge visits 1-3; \$10 ded waived visits 4+ \$55 ded waived 0% after ded; pre-auth req 0% after ded; pre-auth	\$5,300/\$10,600 \$8,450/\$16,900 (incl ded) 50% No charge visits 1-3; 50% after ded visits 4+ 50% after ded 50% after ded; pre-auth req 50% after ded; pre-auth
Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Office Visits Primary Care \$40 ded ware charge preference provider) Specialist Inpatient Services Inpatient Hospital Mental Health Inpatient Outpatient Services Outpatient Facility Lab/X-Ray Mental Health Outpatient \$40 ded ware ware was a service was a serv	aived (No ferred aived ded; pre-auth	\$7,800/\$15,600 (incl ded) 40% No charge visits 1-3; \$35 ded waived visits 4+ \$65 ded waived 40% after ded; pre-auth req 40% after ded; pre-auth	\$6,700/\$13,400 (incl ded) 0% No charge visits 1-3; \$10 ded waived visits 4+ \$55 ded waived 0% after ded; pre-auth req 0% after ded; pre-auth	\$8,450/\$16,900 (incl ded) 50% No charge visits 1-3; 50% after ded visits 4+ 50% after ded 50% after ded; pre-auth req 50% after ded; pre-auth
Individual/Family OOP Limit Co-Insurance Office Visits Primary Care \$40 ded was charge prefe provider) Specialist Inpatient Services Inpatient Hospital Mental Health Inpatient Outpatient Facility Lab/X-Ray Mental Health Outpatient \$8,200/\$16, \$40 ded was charge prefe provider) \$60 ded was limpatient and services Outpatient Services Outpatient Facility \$30% after dered predered predered lab-\$0/\$60 (PCP/SP)/X after ded (Ppre-auth recommendation) Mental Health Outpatient \$40 ded was limpatient and services Mental Health Outpatient	aived (No ferred aived ded; pre-auth	\$7,800/\$15,600 (incl ded) 40% No charge visits 1-3; \$35 ded waived visits 4+ \$65 ded waived 40% after ded; pre-auth req 40% after ded; pre-auth	\$6,700/\$13,400 (incl ded) 0% No charge visits 1-3; \$10 ded waived visits 4+ \$55 ded waived 0% after ded; pre-auth req 0% after ded; pre-auth	\$8,450/\$16,900 (incl ded) 50% No charge visits 1-3; 50% after ded visits 4+ 50% after ded 50% after ded; pre-auth req 50% after ded; pre-auth
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Inpatient Services Inpatient Hospital Mental Health Inpatient Outpatient Services Outpatient Facility Lab/X-Ray Mental Health Outpatient \$40 ded war	ded; pre-auth	40% after ded; pre-auth req 40% after ded; pre-auth	0% after ded; pre-auth req 0% after ded; pre-auth	50% after ded; pre-auth req 50% after ded; pre-auth
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Mental Health Inpatient req 30% after de req Outpatient Services Outpatient Facility \$350 after de req Lab/X-Ray Lab-\$0/\$60 (PCP/SP)/X after ded (P pre-auth rec Mental Health Outpatient \$40 ded was		req 40% after ded; pre-auth	req 0% after ded; pre-auth	req 50% after ded; pre-auth
Outpatient Services Outpatient Facility Lab/X-Ray Lab-\$0/\$60 (PCP/SP)/X after ded (P pre-auth rec Mental Health Outpatient \$40 ded war	ded; pre-auth	1		
Outpatient Facility \$350 after direq Lab/X-Ray Lab-\$0/\$60 (PCP/SP)/X after ded (P pre-auth rec Mental Health Outpatient \$40 ded wa			req	req
Lab/X-Ray req Lab-\$0/\$60 (PCP/SP)/X after ded (P pre-auth rec Mental Health Outpatient \$40 ded wa				
·		\$350 after ded; pre-auth req Lab-\$35/\$65 ded waived (PCP/SP)/X-ray-\$35/\$65 after ded (PCP/SP); pre-auth req	0% after ded; pre-auth req Lab-\$10/\$55 ded waived (PCP/SP); X-ray-0% after ded; pre-auth req	50% after ded; pre-auth req 50% after ded; pre-auth req
·	aived	\$35 ded waived	\$10 ded waived	50% after ded
Emergency Room 40% after de	ded	40% after ded	0% after ded	50% after ded
Urgent Care \$75 ded was	aived	\$75 ded waived	\$75 ded waived	\$75 ded waived
Single 2 x	\$902.12	2 x \$847.11	2 x \$819.16	2 x \$732.11
EE with Spouse 0 x	\$1,804.24	0 x \$1,694.23	0 x \$1,638.34	0 x \$1,464.23
EE with Child(ren) 0 x	\$1,533.61	0 x \$1,440.09	0 x \$1,392.59	0 x \$1,244.59
Family 0 x	\$2,571.04	0 x \$2,414.28	0 x \$2,334.63	0 x \$2,086.51
Monthly Cost 2	\$1,804.24	2 \$1,694.22	2 \$1,638.32	2 \$1,464.22
Annual Cost	\$21,650.88	\$20,330.64	\$19,659.84	\$17,570.64

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	Emblem Millennium EmblemHealth Bronze Value Gated-M (HMOc) (UCR=N/A)		
	In-Network		
Prescription Drugs			
Drug Card	35/0%/0% IntDed T2-3		
Cost Share Information			
Individual/Family Deductible Individual/Family OOP Limit	\$8,550/\$17,100 \$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		
Inpatient Services			
Inpatient Hospital	0% after ded; pre-auth req		
Mental Health 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		
Mental Health Outpatient	0% after ded		
Emergency Care	o /o ditor dod		
Emergency Room	0% after ded		
Urgent Care	\$75 ded waived		
Single	2 x \$694.46	<u> </u>	
EE with Spouse	0 x \$1,388.93		
EE with Child(ren)	0 x \$1,180.58		
Family	0 x \$1,979.21		
Monthly Cost	2 \$1,388.92		
Annual Cost	\$16,667.04		

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