Prepared For: Emblem 2020 2nd qtr NY City Millenium

New York County, NY 10001

Prepared By:

Clifford Grekin Inc. - (631)963-6020

Health Plan Comparison Report (4L)

Effective Date: 04/01/2020

Prepared On: 02/05/2020

SIC: 0000

Report ID: 37461385

Prescription Drugs Drug Card O/30/60 Cost Share Information Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Office Visits Primary Care No charge visits 4+ Specialist Inpatient Services Inpatient Hospital S/30/60 N/A \$2,000/\$4, \$2,000/\$4, \$2,000/\$4, \$2,000/\$4, \$2,000/\$4, \$2,000/\$4, \$2,000/\$4, \$2,000/\$4, \$35,00	,000 e visits 1-3; \$15	\$200/\$400 \$2,400/\$4,800 (incl ded) 0%	In-Network 0/40/80 \$350/\$700 \$5,300/\$10,600 (incl ded)	\$1,900/\$3,800 \$3,700/\$7,400 (incl ded)	
Drug Card O/30/60 Cost Share Information Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Office Visits Primary Care No charge visits 4+ Specialist Inpatient Services Inpatient Hospital Mental Health Inpatient Outpatient Services Outpatient Facility Lab/X-Ray D/30/60 N/A N/A \$2,000/\$4; \$2,000/\$4; \$2,000/\$4; \$2,000/\$4; \$2,000/\$4; \$2,000/\$4; \$35 No charge visits 4+ \$500/admi \$500/admi \$500/admi \$700; pre- Lab/X-Ray PCP-\$15;		\$200/\$400 \$2,400/\$4,800 (incl ded) 0%	\$350/\$700 \$5,300/\$10,600 (incl ded)	\$1,900/\$3,800	
Cost Share Information Individual/Family Deductible Individual/Family OOP Limit Co-Insurance Office Visits Primary Care No charge visits 4+ Specialist Inpatient Services Inpatient Hospital Mental Health Inpatient Outpatient Services Outpatient Facility Lab/X-Ray N/A \$2,000/\$4 \$35 Uncharge visits 4+ \$500/admiter (a) \$500/		\$200/\$400 \$2,400/\$4,800 (incl ded) 0%	\$350/\$700 \$5,300/\$10,600 (incl ded)	\$1,900/\$3,800	_
Individual/Family Deductible Individual/Family OOP Limit \$2,000/\$4, \$2,000/\$4		\$2,400/\$4,800 (incl ded) 0%	\$5,300/\$10,600 (incl ded)		
Individual/Family OOP Limit \$2,000/\$4, Co-Insurance 0% Office Visits Primary Care No charge visits 4+ Specialist \$35 Inpatient Services Inpatient Hospital \$500/admi Mental Health Inpatient \$500/admi Outpatient Services Outpatient Facility \$100; pre- Lab/X-Ray PCP-\$15;		\$2,400/\$4,800 (incl ded) 0%	\$5,300/\$10,600 (incl ded)		
Office Visits Primary Care No charge visits 4+ Specialist Inpatient Services Inpatient Hospital Mental Health Inpatient Services Outpatient Services Outpatient Facility S100; pre- Lab/X-Ray PCP-\$15;	e visits 1-3; \$15				
visits 4+ Specialist \$35 Inpatient Services Inpatient Hospital \$500/admi Mental Health Inpatient \$500/admi Outpatient Services Outpatient Facility \$100; pre- Lab/X-Ray PCP-\$15;	e visits 1-3; \$15	No charge visits 1 3: \$15	30%	30%	
Inpatient Services Inpatient Hospital \$500/admi Mental Health Inpatient \$500/admi Outpatient Services Outpatient Facility \$100; pre- Lab/X-Ray PCP-\$15;		ded waived visits 4+	No charge visits 1-3; \$40 ded waived visits 4+	No charge visits 1-3; \$25 ded waived visits 4+	
Inpatient Hospital \$500/admi Mental Health Inpatient \$500/admi Outpatient Services Outpatient Facility \$100; pre- Lab/X-Ray PCP-\$15;		\$35 ded waived	\$60 ded waived	\$40 ded waived	
Mental Health Inpatient \$500/admi Outpatient Services Outpatient Facility \$100; pre- Lab/X-Ray PCP-\$15;					
Outpatient Services Outpatient Facility \$100; pre- Lab/X-Ray PCP-\$15;	it; pre-auth req	\$500/admit after ded; pre-auth req	30% after ded; pre-auth req	30% after ded; pre-auth req	
Outpatient Facility \$100; pre- Lab/X-Ray PCP-\$15;	it; pre-auth req	\$500/admit after ded; pre-auth req	30% after ded; pre-auth req	30% after ded; pre-auth req	
Lab/X-Ray PCP-\$15;			·		
,	-auth req	\$100 after ded; pre-auth req	\$200 after ded; pre-auth req	\$200 after ded; pre-auth req	
		Lab-\$15/\$35 ded waived (PCP/SP); X-ray-\$15/\$35 after ded (PCP/SP); pre-auth req	Lab-\$40/\$60 ded waived (PCP/SP); X-ray-\$40/\$60 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 \$35		\$35 ded waived	\$40 ded waived	\$25 ded waived	
Emergency Care					
Emergency Room \$350 (waix	ved if admitted)	\$350 (waived if admitted) after ded	\$600 (waived if admitted) after ded	\$500 (waived if admitted) after ded	
Urgent Care \$75		\$75 ded waived	\$75 ded waived	\$75 ded waived	
Single 2 x	\$916.19	2 x \$894.18	2 x \$748.20	2 x \$710.57	
EE with Spouse 0 x	\$1,832.39	0 x \$1,788.35	0 x \$1,496.39	0 x \$1,421.14	
EE with Child(ren) 0 x	\$1,557.54	0 x \$1,520.10	0 x \$1,271.93	0 x \$1,207.96	
Family 0 x	\$2,611.16	0 x \$2,548.41	0 x \$2,132.36	0 x \$2,025.12	
Monthly Cost 2	\$1,832.38	2 \$1,788.36	2 \$1,496.40	2 \$1,421.14	
Annual Cost	\$21,988.56	\$21,460.32	\$17,956.80	\$17,053.68	

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	Emblem Millennium EmblemHealth Silver Premier Gated-M (HM (UCR=N/A)	Emblem Millennium IOc) EmblemHealth Silver Value Gated-M (HMOc) (UCR=N/A)	Emblem Millennium EmblemHealth Bronze Premier Gated-M (HMOc) (UCR=N/A)	Emblem Millennium EmblemHealth Bronze Value Gated-M (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	25/50%/50% IntDed	35/0%/0% IntDed T2-3
Cost Share Information				
Individual/Family Deductible Individual/Family OOP Limit	\$2,400/\$4,800 \$7,800/\$15,600 (incl ded)	\$6,300/\$12,600 \$6,300/\$12,600 (incl ded)	\$4,600/\$9,200 \$7,900/\$15,800 (incl ded)	\$8,150/\$16,300 \$8,150/\$16,300 (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; \$40 after ded visits 4+	No charge visits 1-3; 0% after ded visits 4+
Specialist	\$65 ded waived	\$55 ded waived	\$70 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	l l			
Outpatient Facility	\$250 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	Lab-\$40/\$70 after ded (PCP/SP); X-ray-50% after ded; pre-auth req	0% after ded; pre-auth req
Mental Health Outpatient	\$35 ded waived	\$10 ded waived	\$40 after ded	0% after ded
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 \$629.54	2 x \$608.56	2 x \$542.13	2 x \$517.55
EE with Spouse	0 x \$1,259.09	0 x \$1,217.13	0 x \$1,084.26	0 x \$1,035.10
EE with Child(ren)	0 x \$1,070.22	0 x \$1,034.55	0 x \$921.63	0 x \$879.84
Family	0 x \$1,794.20	0 x \$1,734.40	0 x \$1,545.08	0 x \$1,475.03
Monthly Cost Annual Cost	2 \$1,259.08 \$15,108.96	2 \$1,217.12 \$14,605.44	2 \$1,084.26 \$13,011.12	2 \$1,035.10 \$12,421.20
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