

	Emblem Millennium EmblemHealth Platinum Premier Gated-M (HMO) (UCR=N/A)		Emblem Millennium 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		0/30/65 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	\$1,335.83	2 x	\$1,298.51	2 x	\$1,087.58	2 x	\$1,027.48
EE with Spouse	0 x	\$2,671.64	0 x	\$2,597.02	0 x	\$2,175.16	0 x	\$2,054.96
EE with Child(ren)	0 x	\$2,270.89	0 x	\$2,207.48	0 x	\$1,848.88	0 x	\$1,746.71
Family	0 x	\$3,807.09	0 x	\$3,700.76	0 x	\$3,099.60	0 x	\$2,928.32
Monthly Cost	2	\$2,671.66	2	\$2,597.02	2	\$2,175.16	2	\$2,054.96
Annual Cost		\$32,059.92		\$31,164.24		\$26,101.92		\$24,659.52

	Emblem Millennium EmblemHealth Gold Virtual EPO Gated-M (EPOc) (UCR=N/A)		Emblem Millennium EmblemHealth Silver Premier Gated-M (HMOc) (UCR=N/A)		Emblem Millennium EmblemHealth Silver Value Gated-M (HMOc) (UCR=N/A)		Emblem Millennium EmblemHealth Bronze Premier Gated-M (HMOc) (UCR=N/A)	
	In-Network	Out-Network	In-Network		In-Network		In-Network	
Prescription Drugs								
Drug Card	0/40/80 IntDed T2-3		0/40/80		0%/0%/0% IntDed T2-3		50/50%/50% IntDed T2-3	
Cost Share Information								
Individual/Family Deductible	\$1,700/\$3,400		\$3,800/\$7,600		\$7,000/\$14,000		\$5,500/\$11,000	
Individual/Family OOP Limit	\$8,200/\$16,400 (incl ded)		\$8,000/\$16,000 (incl ded)		\$7,000/\$14,000 (incl ded)		\$8,700/\$17,400 (incl ded)	
Co-Insurance	30%		40%		0%		50%	
Office Visits								
Primary Care	\$40 ded waived (No charge preferred provider)		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+	
Specialist	\$60 ded waived		\$65 ded waived		\$55 ded waived		50% after ded	
Inpatient Services								
Inpatient Hospital	30% after ded; pre-auth req		40% after ded; pre-auth req		0% after ded; pre-auth req		50% after ded; pre-auth req	
Mental Health Inpatient	30% after ded; pre-auth req		40% after ded; pre-auth req		0% after ded; pre-auth req		50% after ded; pre-auth req	
Outpatient Services								
Outpatient Facility	\$350 after ded; pre-auth req		\$350 after ded; pre-auth req		0% after ded; pre-auth req		50% after ded; pre-auth req	
Lab/X-Ray	Lab-\$0/\$60 ded waived (PCP/SP)/X-ray-\$40/\$60 after ded (PCP/SP); pre-auth req		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	
Mental Health Outpatient	\$40 ded waived		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+	
Emergency Care								
Emergency Room	40% after ded		40% after ded		0% after ded		50% after ded	
Urgent Care	\$75 ded waived		\$75 ded waived		\$75 ded waived		\$75 ded waived	
Single	2 x	\$1,010.30	2 x	\$931.14	2 x	\$900.42	2 x	\$804.69
EE with Spouse	0 x	\$2,020.60	0 x	\$1,862.30	0 x	\$1,800.84	0 x	\$1,609.38
EE with Child(ren)	0 x	\$1,717.51	0 x	\$1,582.95	0 x	\$1,530.71	0 x	\$1,367.97
Family	0 x	\$2,879.35	0 x	\$2,653.78	0 x	\$2,566.19	0 x	\$2,293.38
Monthly Cost	2	\$2,020.60	2	\$1,862.28	2	\$1,800.84	2	\$1,609.38
Annual Cost		\$24,247.20		\$22,347.36		\$21,610.08		\$19,312.56

Prepared For: **Emblem 2022 3rd qtr Millenium Nassau Suffolk**

Nassau County, NY 11565

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

Health Plan Comparison Report (4L)

Effective Date: 07/01/2022

Prepared On: 04/15/2022

Report ID: 38638487

SIC: 0000

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	\$8,550/\$17,100
Individual/Family OOP Limit	\$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	No charge visits 1-3; 0% after ded visits 4+
Emergency Care	
Emergency Room	0% after ded
Urgent Care	\$75 ded waived
Single	2 x \$763.30
EE with Spouse	0 x \$1,526.59
EE with Child(ren)	0 x \$1,297.60
Family	0 x \$2,175.40
Monthly Cost	2 \$1,526.60
Annual Cost	\$18,319.20

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