Prepared For: Healthfirst 2021 4th qtr Pro Plus plans
New York County, NY 10001
Prepared By: Clifford Grekin Inc. - (631)963-6020

Health Plan Comparison Report (3P)
Effective Date: 10/01/2021 Prepared On: 07/19/2021
Report ID: 38365782 SIC: 0000

	HealthFirst Gold Pro Plus EPO (EPO) (UCR=N/A)		**HealthFirst Gold 25/50/0 Pro Plus EPO (EPO) (UCR=N/A)**		**HealthFirst Silver Pro Plus EPO (EPOc) (UCR=N/A)**	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs						
Drug Card	10/50/85		10/50/85		20/60/110	
Cost Share Information						
Individual/Family Deductible	N/A		N/A		$4,300/$8,600	
Individual/Family OOP Limit	$5,250/$10,500 (incl ded)		$7,000/$14,000 (incl ded)		$8,150/$16,300 (incl ded)	
Co-Insurance	0%		0%		40%	
Office Visits						
Primary Care	$25		$25		$35 ded waived	
Specialist	$40		$50		$70 ded waived	
Maternity Prenatal/Postnatal Care	No charge		No charge		No charge	
Chiropractic Care	$40		$50		$70 ded waived	
Inpatient Services						
Inpatient Hospital	$500/admit		$500/admit		40% after ded	
Mental Health Inpatient	$500/admit		$500/admit		40% after ded	
Substance Abuse Inpatient	$500/admit		$500/admit		40% after ded	
Outpatient Services						
Outpatient Facility	$300		$300		40% after ded	
Lab/X-Ray	PCP-$25; SP-$40		PCP-$25; SP-$50		PCP-$35 ded waived; SP-$70 ded waived	
Advanced Radiology	$40		$50		$70 ded waived	
Mental Health Outpatient	$25		$25		$35 ded waived	
Substance Abuse Outpatient	$25		$25		$35 ded waived	
Emergency Care						
Emergency Room	$350 (waived if admitted)		$350 (waived if admitted)		$600 (waived if admitted) after ded	
Ambulance	$150		$150		$300 after ded	
Urgent Care	$60		$60		$70 ded waived	
Recovery/Special Needs						
Home Health Care	$25; 40 visits/plan yr		$25; 40 visits/plan yr		$35 after ded; 40 visits/plan yr	
Skilled Nursing	$500/admit; 200 days/plan yr		$500/admit; 200 days/plan yr		40% after ded; 200 days/plan yr	
Durable Medical Equipment	15%		15%		40% after ded	
Single	2 x $798.64		2 x $766.68		2 x $686.25	
EE with Spouse	0 x $1,597.28		0 x $1,533.36		0 x $1,372.50	
EE with Child(ren)	0 x $1,357.69		0 x $1,303.36		0 x $1,166.63	
Family	0 x $2,276.12		0 x $2,185.04		0 x $1,955.81	
Monthly Cost	2 $1,597.28		2 $1,533.36		2 $1,372.50	
Annual Cost	$19,167.36		$18,400.32		$16,470.00	

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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	HealthFirst Silver 40/75/4700 Pro Plus EPO (EPOc) (UCR=N/A)		**HealthFirst Bronze Pro Plus EPO (HSA Compatible) (HSA) (UCR=N/A)**		**HealthFirst Bronze 6850 Pro Plus EPO (HSA Compatible) (HSA) (UCR=N/A)**	
	In-Network	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Prescription Drugs						
Drug Card	20/60/110		50%/50%/50% IntDed		0%/0%/0% IntDed	
Cost Share Information						
Individual/Family Deductible	$4,700/$9,400		$5,950/$11,900		$6,850/$13,700	
Individual/Family OOP Limit	$7,900/$15,800 (incl ded)		$6,900/$13,800 (incl ded)		$6,850/$13,700 (incl ded)	
Co-Insurance	45%		50%		0%	
Office Visits						
Primary Care	$40 ded waived		50% after ded		0% after ded	
Specialist	$75 ded waived		50% after ded		0% after ded	
Maternity Prenatal/Postnatal Care	No charge		No charge		No charge	
Chiropractic Care	$75 ded waived		50% after ded		0% after ded	
Inpatient Services						
Inpatient Hospital	45% after ded		50% after ded		0% after ded	
Mental Health Inpatient	45% after ded		50% after ded		0% after ded	
Substance Abuse Inpatient	45% after ded		50% after ded		0% after ded	
Outpatient Services						
Outpatient Facility	45% after ded		50% after ded		0% after ded	
Lab/X-Ray	PCP-$40 ded waived; SP-$75 ded waived		50% after ded		0% after ded	
Advanced Radiology	$75 ded waived		50% after ded		0% after ded	
Mental Health Outpatient	$40 ded waived		50% after ded		0% after ded	
Substance Abuse Outpatient	$40 ded waived		50% after ded		0% after ded	
Emergency Care						
Emergency Room	$600 (waived if admitted) after ded		50% after ded		0% after ded	
Ambulance	$300 after ded		50% after ded		0% after ded	
Urgent Care	$75 ded waived		50% after ded		0% after ded	
Recovery/Special Needs						
Home Health Care	$40 after ded; 40 visits/plan yr		50% after ded; 40 visits/plan yr		0% after ded; 40 visits/plan yr	
Skilled Nursing	45% after ded; 200 days/plan yr		50% after ded; 200 days/plan yr		0% after ded; 200 days/plan yr	
Durable Medical Equipment	45% after ded		50% after ded		0% after ded	
Single	2 x $667.72		2 x $573.75		2 x $543.34	
EE with Spouse	0 x $1,335.44		0 x $1,147.50		0 x $1,086.68	
EE with Child(ren)	0 x $1,135.12		0 x $975.38		0 x $923.68	
Family	0 x $1,903.00		0 x $1,635.19		0 x $1,548.52	
Monthly Cost	2 $1,335.44		2 $1,147.50		2 $1,086.68	
Annual Cost	$16,025.28		$13,770.00		$13,040.16	

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