

	HealthFirst Gold Pro EPO (EPO) (UCR=N/A)		HealthFirst Gold 25/50/0 Pro EPO (EPO) (UCR=N/A)		HealthFirst Silver Pro EPO (EPOc) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
<b>Prescription Drugs</b>						
Drug Card	10/50/85		10/50/85		20/60/110	
<b>Cost Share Information</b>						
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%	
<b>Office Visits</b>						
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	
<b>Inpatient Services</b>						
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	
<b>Outpatient Services</b>						
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	
<b>Emergency Care</b>						
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	
<b>Recovery/Special Needs</b>						
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      \$771.63		2 x      \$740.77		2 x      \$663.04	
EE with Spouse	0 x      \$1,543.26		0 x      \$1,481.54		0 x      \$1,326.08	
EE with Child(ren)	0 x      \$1,311.77		0 x      \$1,259.31		0 x      \$1,127.17	
Family	0 x      \$2,199.15		0 x      \$2,111.19		0 x      \$1,889.66	
Monthly Cost	2      \$1,543.26		2      \$1,481.54		2      \$1,326.08	
Annual Cost	\$18,519.12		\$17,778.48		\$15,912.96	

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	HealthFirst Silver 40/75/4700 Pro EPO (EPOc) (UCR=N/A)		HealthFirst Bronze Pro EPO (HSA Compatible) (HSA) (UCR=N/A)		HealthFirst Bronze 6850 Pro EPO (HSA Compatible) (HSA) (UCR=N/A)	
	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
<b>Prescription Drugs</b>						
Drug Card	20/60/110		50%/50%/50% IntDed		0%/0%/0% IntDed	
<b>Cost Share Information</b>						
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%	
<b>Office Visits</b>						
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	
<b>Inpatient Services</b>						
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	
<b>Outpatient Services</b>						
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	
<b>Emergency Care</b>						
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	
<b>Recovery/Special Needs</b>						
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      \$645.13		2 x      \$554.35		2 x      \$524.98	
EE with Spouse	0 x      \$1,290.26		0 x      \$1,108.70		0 x      \$1,049.96	
EE with Child(ren)	0 x      \$1,096.72		0 x      \$942.40		0 x      \$892.47	
Family	0 x      \$1,838.62		0 x      \$1,579.90		0 x      \$1,496.19	
Monthly Cost	2      \$1,290.26		2      \$1,108.70		2      \$1,049.96	
Annual Cost	\$15,483.12		\$13,304.40		\$12,599.52	

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

**Health Plan Comparison Report (3P)**  
 Effective Date: 10/01/2021  
 Report ID: 38365784  
 Prepared On: 07/19/2021  
 SIC: 0000

	<b>HealthFirst Bronze 8150 Pro EPO (EPOc) (UCR=N/A)</b>	
	<b>In-Network</b>	<b>Out-Network</b>
<b>Prescription Drugs</b>		
Drug Card	0%/0%/0% IntDed	
<b>Cost Share Information</b>		
Individual/Family Deductible	\$8,150/\$16,300	
Individual/Family OOP Limit	\$8,150/\$16,300 (includ ed)	
Co-Insurance	0%	
<b>Office Visits</b>		
Primary Care	0% after ded	
Specialist	0% after ded	
Maternity Prenatal/Postnatal Care	No charge	
Chiropractic Care	0% after ded	
<b>Inpatient Services</b>		
Inpatient Hospital	0% after ded	
Mental Health Inpatient	0% after ded	
Substance Abuse Inpatient	0% after ded	
<b>Outpatient Services</b>		
Outpatient Facility	0% after ded	
Lab/X-Ray	0% after ded	
Advanced Radiology	0% after ded	
Mental Health Outpatient	0% after ded	
Substance Abuse Outpatient	0% after ded	
<b>Emergency Care</b>		
Emergency Room	0% after ded	
Ambulance	0% after ded	
Urgent Care	0% after ded	
<b>Recovery/Special Needs</b>		
Home Health Care	0% after ded; 40 visits/plan yr	
Skilled Nursing	0% after ded; 200 days/plan yr	
Durable Medical Equipment	0% after ded	
Single	2 x	\$505.64
EE with Spouse	0 x	\$1,011.28
EE with Child(ren)	0 x	\$859.59
Family	0 x	\$1,441.07
Monthly Cost	2	\$1,011.28
Annual Cost		\$12,135.36

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