healthfirst®
Health Insurance for New Yorkers

Healthfirst Pro Plus EPO Plans

We're here for small business owners, employees, and their families, with health insurance plans that fit their needs. With an emphasis on comprehensive coverage, highlights of the Healthfirst Pro Plus EPO plans include benefits such as:

- Vision and dental benefits for all ages
- $0 copay for access to 24/7 telemedicine*
- Up to $600 in exercise rewards for individuals and covered spouses
- Coverage for acupuncture visits

In addition, we'll cover important health benefits such as:

- No-cost annual checkups
- Urgent care visits
- Hospital stays
- Lab tests (blood tests and X-rays)
- Maternity and newborn care
- Prescription drugs
- And more!

To enroll in a Healthfirst Pro Plus EPO plan, please talk to your broker or call Healthfirst at 1-844-785-1652, Monday to Friday, 9am—5pm.

Third Quarter Rates 2020

	Platinum Pro Plus EPO	Gold Pro Plus EPO	Gold 25/50/0 Pro Plus EPO	Silver Pro Plus EPO	Silver 40/75/4700 Pro Plus EPO	Bronze Pro Plus EPO (HSA Compatible)	Bronze 6650 Pro Plus EPO (HSA Compatible)
Single	$912.75	$776.69	$745.62	$667.38	$649.37	$557.99	$528.41
Couple	$1,825.50	$1,553.38	$1,491.24	$1,334.76	$1,298.74	$1,115.98	$1,056.82
Parent w/ Child(ren)	$1,551.68	$1,320.37	$1,267.55	$1,134.55	$1,103.93	$948.58	$898.30
Family	$2,601.34	$2,213.57	$2,125.02	$1,902.03	$1,850.70	$1,590.27	$1,505.97

*Bronze Pro Plus must meet the deductible before the $0 copay applies.

Costs (Individual/Family)							
	Platinum Pro Plus EPO	Gold Pro Plus EPO	Gold 25/50/0 Pro Plus EPO	Silver Pro Plus EPO	Silver 40/75/4700 Pro Plus EPO	Bronze Pro Plus EPO (HSA Compatible)	Bronze 6650 Pro Plus EPO (HSA Compatible)
Deductible	$0/$0	$0/$0	$0/$0	$4,300/$8,600	$4,700/$9,400	$4,500/$9,000	$6,650/$13,300
Maximum Out-of-Pocket Cost	$2,000/$4,000	$5,000/$10,000	$7,000/$14,000	$8,150/$16,300	$7,900/$15,800	$6,750/$13,500	$6,650/$13,300
Quick Reference Guide							
Your Annual Checkup (Preventive Care)	$0–No deductible or cost sharing applies to recommended preventive care visits or services						
Primary Care Provider (PCP) Visit	$20 copay	$25 copay	$25 copay	$35 copay	$40 copay	20% coinsurance after deductible	0% coinsurance after deductible
Specialist Visit	$35 copay	$40 copay	$50 copay	$70 copay	$75 copay	20% coinsurance after deductible	0% coinsurance after deductible
Urgent Care	$50 copay	$60 copay	$60 copay	$70 copay	$75 copay	20% coinsurance after deductible	0% coinsurance after deductible
Emergency Room	$250 copay	$350 copay	$350 copay	$600 copay after deductible	$600 copay after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Ambulance	$150 copay	$150 copay	$150 copay	$300 copay after deductible	$300 copay after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Surgeon	$100 copay	$100 copay	$100 copay	$200 copay after deductible	$200 copay after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Outpatient Facility	$200 copay	$300 copay	$300 copay	40% coinsurance after deductible	45% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Inpatient Facility/Skilled Nursing Facility	$500 copay	$500 copay	$500 copay	40% coinsurance after deductible	45% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Physical, Occupational, and Speech Therapies	$35 copay	$40 copay	$50 copay	$70 copay	$75 copay	20% coinsurance after deductible	0% coinsurance after deductible
Dental (Preventive Care)	$20 copay	$25 copay	$25 copay	$35 copay	$40 copay	20% coinsurance after deductible	0% coinsurance after deductible
Dental (Routine Care)	$20 copay	$25 copay	$25 copay	$35 copay after deductible	$40 copay after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Dental (Major Care)	10% coinsurance	15% coinsurance	15% coinsurance	40% coinsurance after deductible	45% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
Vision Exam	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay after deductible	0% coinsurance after deductible
Eyeglass Lenses, Frames, and Contact Lenses*	$25 copay	$25 copay	$25 copay	$25 copay	$25 copay	$25 copay after deductible	0% coinsurance after deductible
Acupuncture	$35 copay	$40 copay	$50 copay	$70 copay	$75 copay	20% coinsurance after deductible	0% coinsurance after deductible
Telemedicine	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay after deductible	$0 copay after deductible
Prescription Drugs (30-day supply)							
Generic (Tier 1)**	$10 copay	$10 copay	$10 copay	$20 copay	$20 copay	20% coinsurance after deductable	0% coinsurance after deductible
Preferred (Tier 2)	$30 copay	$50 copay	$50 copay	$60 copay	$60 copay	20% coinsurance after deductible	0% coinsurance after deductible
Non-Preferred (Tier 3)	$60 copay	$85 copay	$85 copay	$110 copay	$110 copay	20% coinsurance after deductible	0% coinsurance after deductible

*A $130 allowance applies to eyeglasses and contact lenses; copay applies to contact lens fitting.

**May also include low-cost brands.

Coverage is provided by Healthfirst Health Plan, Inc., Healthfirst PHSP, Inc., and/or Healthfirst Insurance Company, Inc. (together, "Healthfirst").

Plans contain exclusions and limitations. The benefit information provided is a brief summary, not a complete description, of benefits.