healthfirst®
Health Insurance for New Yorkers

Healthfirst Pro Plus EPO Plans

We offer a broad range of health insurance plans to fit the needs and budget of small business owners, employees, and their families. 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* (talk to doctors by phone or video chat)
- 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
- Retail health clinic and urgent care visits
- Hospital stays
- Lab tests (blood tests and X-rays)
- Maternity and newborn care
- Prescription drugs (same-day delivery and mail-order options available)
- 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.

First Quarter Rates 2023 - Long Island

		Platinum Pro Plus EPO	Gold 1350 Pro Plus EPO	Silver Pro Plus EPO	Silver 45/75/4300 Pro Plus EPO	Bronze 6850 Pro Plus EPO (HSA Compatible)
Single	Standard	$1,077.14	$859.55	$787.58	$766.31	$623.58
	Age 29	$1,087.91	$868.14	$795.45	$773.97	$629.82
Couple	Standard	$2,154.28	$1,719.10	$1,575.16	$1,532.62	$1,247.16
	Age 29	$2,175.82	$1,736.28	$1,590.90	$1,547.94	$1,259.64
Parent w/Child(ren)	Standard	$1,831.14	$1,461.24	$1,338.89	$1,302.73	$1,060.09
	Age 29	$1,849.45	$1,475.84	$1,352.27	$1,315.75	$1,070.69
Family	Standard	$3,069.85	$2,449.72	$2,244.60	$2,183.98	$1,777.20
	Age 29	$3,100.54	$2,474.20	$2,267.03	$2,205.81	$1,794.99

*Bronze 6850 Pro Plus must meet the deductible before the $0 copay applies.

**The wellness/exercise reward is in the form of a prepaid gift card which should be used on a product or a service that promotes good health.

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Costs (Individual/Family)					
	Platinum Pro Plus EPO	**Gold 1350 Pro Plus EPO**	**Silver Pro Plus EPO**	**Silver 45/75/4300 Pro Plus EPO**	**Bronze 6850 Pro Plus EPO (HSA Compatible)**
Deductible	$0/$0	$1,350/$2,700	$4,300/$8,600	$4,300/$8,600	$6,850/$13,700
Maximum Out-of-Pocket Cost	$2,000/$4,000	$7,900/$15,800	$8,150/$16,300	$8,150/$16,300	$6,850/$13,700
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	$35 copay	$45 copay	0% coinsurance ††
Specialist Visit†	$35 copay	$70 copay	$70 copay	$75 copay	0% coinsurance ††
Urgent Care	$50 copay	$60 copay ††	$70 copay ††	$75 copay ††	0% coinsurance ††
Emergency Room	$250 copay	$600 copay ††	$600 copay ††	$600 copay ††	0% coinsurance ††
Ambulance	$150 copay	$150 copay ††	$300 copay ††	$300 copay ††	0% coinsurance ††
Surgeon	$100 copay	20% coinsurance ††	$200 copay ††	$200 copay ††	0% coinsurance ††
Outpatient Facility	$200 copay	20% coinsurance ††	40% coinsurance ††	40% coinsurance ††	0% coinsurance ††
Inpatient Facility/Skilled Nursing Facility	$500 copay	20% coinsurance ††	40% coinsurance ††	40% coinsurance ††	0% coinsurance ††
Physical, Occupational, and Speech Therapies	$35 copay	$70 copay ††	$70 copay ††	$75 copay ††	0% coinsurance ††
Dental (Preventive Care)	$20 copay	$25 copay	$35 copay	$45 copay	0% coinsurance ††
Dental (Routine Care)	$20 copay	$25 copay	$35 copay ††	$45 copay ††	0% coinsurance ††
Dental (Major Care)	10% coinsurance	20% coinsurance ††	40% coinsurance ††	40% coinsurance ††	0% coinsurance ††
Vision Exam	$10 copay	$10 copay	$10 copay	$10 copay	0% coinsurance ††
Eyeglass Lenses, Frames, and Contact Lenses*	$25 copay	$25 copay	$25 copay	$25 copay	0% coinsurance ††
Acupuncture (up to 30 visits per year)	$35 copay	$70 copay ††	$70 copay ††	$75 copay ††	0% coinsurance ††
Telemedicine§ (Teladoc)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay ††
Prescription Drugs (30-day supply)					
Generic (Tier 1)**	$10 copay	$20 copay	$20 copay	$20 copay	0% coinsurance ††
Preferred (Tier 2)	$30 copay	$60 copay	$60 copay	$60 copay	0% coinsurance ††
Non-Preferred (Tier 3)	$60 copay	$110 copay	$110 copay	$110 copay	0% coinsurance ††

*A $130 allowance applies to eyeglasses and contact lenses; copay applies to contact lens fitting. **May also include low-cost brands.
†Copay applies to both in-person and virtual visits. ††Subject to deductible.
§Telemedicine (Teladoc) isn't a replacement for your primary care provider (PCP). Your PCP should always be your first choice for care (both in-person and virtual visits).
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.