

# 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 get a quote or more information about our Pro Plus Plans, please contact Healthfirst at **1-844-785-1652**, Monday to Friday, 9am–5pm.

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)
<b>Deductible</b>	\$0/\$0	\$0/\$0	\$0/\$0	\$2,950/\$5,900	\$4,700/\$9,400	\$4,000/\$8,000	\$6,650/\$13,300
<b>Maximum Out-of-Pocket Cost</b>	\$2,000/\$4,000	\$5,000/\$10,000	\$7,000/\$14,000	\$7,900/\$15,800	\$7,900/\$15,800	\$6,650/\$13,300	\$6,650/\$13,300
Quick Reference Guide							
<b>Your Annual Checkup (Preventive Care)</b>	\$0—No deductible or cost sharing applies to recommended preventive care visits or services	\$0—No deductible or cost sharing applies to recommended preventive care visits or services	\$0—No deductible or cost sharing applies to recommended preventive care visits or services	\$0—No deductible or cost sharing applies to recommended preventive care visits or services	\$0—No deductible or cost sharing applies to recommended preventive care visits or services	\$0—No deductible or cost sharing applies to recommended preventive care visits or services	\$0—No deductible or cost sharing applies to recommended preventive care visits or services
<b>Primary Care Provider (PCP) Visit</b>	\$20 copay	\$25 copay	\$25 copay	\$35 copay	\$40 copay	20% coinsurance after deductible	0% coinsurance after deductible
<b>Specialist Visit</b>	\$35 copay	\$40 copay	\$50 copay	\$70 copay	\$75 copay	20% coinsurance after deductible	0% coinsurance after deductible
<b>Urgent Care</b>	\$50 copay	\$60 copay	\$60 copay	\$70 copay	\$75 copay	20% coinsurance after deductible	0% coinsurance after deductible
<b>Emergency Room</b>	\$250 copay	\$350 copay	\$350 copay	\$600 copay after deductible	\$600 copay after deductible	20% coinsurance after deductible	0% coinsurance after deductible
<b>Ambulance</b>	\$150 copay	\$150 copay	\$150 copay	\$300 copay after deductible	\$300 copay after deductible	20% coinsurance after deductible	0% coinsurance after deductible
<b>Surgeon</b>	\$100 copay	\$100 copay	\$100 copay	\$200 copay after deductible	\$200 copay after deductible	20% coinsurance after deductible	0% coinsurance after deductible
<b>Outpatient Facility</b>	\$200 copay	\$300 copay	\$300 copay	40% coinsurance after deductible	45% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
<b>Inpatient Facility/Skilled Nursing Facility</b>	\$500 copay	\$500 copay	\$500 copay	40% coinsurance after deductible	45% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
<b>Physical, Occupational, and Speech Therapies</b>	\$35 copay	\$40 copay	\$50 copay	\$70 copay	\$75 copay	20% coinsurance after deductible	0% coinsurance after deductible
<b>Dental (Preventive Care)</b>	\$20 copay	\$25 copay	\$25 copay	\$35 copay	\$40 copay	20% coinsurance after deductible	0% coinsurance after deductible
<b>Dental (Routine Care)</b>	\$20 copay	\$25 copay	\$25 copay	\$35 copay after deductible	\$40 copay after deductible	20% coinsurance after deductible	0% coinsurance after deductible
<b>Dental (Major Care)</b>	10% coinsurance	15% coinsurance	15% coinsurance	40% coinsurance after deductible	45% coinsurance after deductible	20% coinsurance after deductible	0% coinsurance after deductible
<b>Vision Exam</b>	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay	\$10 copay after deductible	0% coinsurance after deductible
<b>Eyeglass Lenses, Frames, and Contact Lenses*</b>	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay	\$25 copay after deductible	0% coinsurance after deductible
<b>Acupuncture</b>	\$35 copay	\$40 copay	\$50 copay	\$70 copay	\$75 copay	20% coinsurance after deductible	0% coinsurance after deductible
<b>Telemedicine</b>	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay	\$0 copay after deductible	\$0 copay after deductible
Prescription Drugs (30-day supply)							
<b>Generic (Tier 1)</b>	\$10 copay	\$10 copay	\$10 copay	\$20 copay	\$20 copay	20% coinsurance after deductible	0% coinsurance after deductible
<b>Brand Name Preferred (Tier 2)</b>	\$30 copay	\$50 copay	\$50 copay	\$60 copay	\$60 copay	20% coinsurance after deductible	0% coinsurance after deductible
<b>Brand Name Non-Preferred (Tier 3)</b>	\$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.

Plans are offered by affiliates of Healthfirst, Inc. Plans contain exclusions and limitations. The benefit information provided is a brief summary, not a complete description, of benefits.