This is only a summary. The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, 1-855-789-3668 For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthfirstny.org or call 1-855-789-3668 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care, prenatal care and telemedicine are covered before you meet your deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Individual **$5,000/** Family **$10,000**	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premium, Balance Billing charges and the cost of health care services this plan does not cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthfirstny.org or call 1-855-789-3668 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

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Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay	Not Covered	----------None----------
	Specialist visit	$40 co-pay	Not Covered	----------None----------
	Preventive care/screening/ immunization	No Charge	Not Covered	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	$25 co-pay when performed in a PCP's office or $40 co-pay when performed in an outpatient facility	Not Covered	Preauthorization Required
	Imaging (CT/PET scans, MRIs)	$40 co-pay when performed in an outpatient facility	Not Covered	Preauthorization Required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthfirstny.org	Generic drugs	$10 co-pay /30 day prescription (retail) and $20 co-pay /90 day prescription (mail order)	Not Covered	Covers up to a 30-day supply (retail prescription) or up to a 90-day supply (mail order prescription)
	Preferred brand drugs	$50 co-pay /30 day prescription (retail) and $100 co-pay /90 day prescription (mail order)	Not Covered	Covers up to a 30-day supply (retail prescription) or up to a 90-day supply (mail order prescription)
	Non-preferred brand drugs	$85 co-pay /30 day prescription (retail) and $170 co-pay /90	Not Covered	Covers up to a 30-day supply (retail prescription) or up to a 90-day supply (mail order prescription)

* For more information about limitations and exceptions, see the plan or policy document at www.healthfirstny.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		day prescription (mail order)		
	Specialty drugs	$85 co-pay /30 day prescription (retail) and $170 co-pay /90 day prescription (mail order)	Not Covered	Covers up to a 30-day supply (retail prescription) or up to a 90-day supply (mail order prescription)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay	Not Covered	Preauthorization Required
	Physician/surgeon fees	$100 copay	Not Covered	Applies only to surgery performed in a hospital outpatient facility setting, including freestanding surgicenters, not to office surgery.
If you need immediate medical attention	Emergency room care	$350 co-pay per visit	$350 co-pay per visit	Co-pay / Co-insurance waived if Hospital admission
	Emergency medical transportation	$150 co-pay /occurrence	$150 co-pay/occurrence	----------None----------
	Urgent care	$60 co-pay	Not Covered	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500/day, $1500 max/admit	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
	Physician/surgeon fees	$100 copay	Not Covered	Applies only to surgery performed in a hospital inpatient or hospital outpatient facility setting, including freestanding surgicenters, not to office surgery.

* For more information about limitations and exceptions, see the plan or policy document at www.healthfirstny.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay	Not Covered	----------None----------
	Inpatient services	$500/day, $1500 max/admit	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
If you are pregnant	Office visits	Covered in Full	Not Covered	If Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA
	Childbirth/delivery professional services	$100 co-pay	Not Covered	----------None----------
	Childbirth/delivery facility services	$500/day, $1500 max/admit	Not Covered	Preauthorization Required
If you need help recovering or have other special health needs	Home health care	$25 Co-pay	Not Covered	Preauthorization Required. 40 visits per plan year
	Rehabilitation services	$40 Co-pay	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies
	Habilitation services	$40 Co-pay	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies
	Skilled nursing care	$500/day, $1500 max/admit	Not Covered	Preauthorization Required; 200 days per plan year
	Durable medical equipment	15% Coinsurance	Not Covered	Preauthorization Required
	Hospice services	$500/day, $1500 max/admit (inpatient) or $25 Copay (outpatient)	Not Covered	Preauthorization Required; 210 days per plan year (inpatient); 5 Visits for Family Bereavement Counseling (outpatient)
If your child needs dental or eye care	Children's eye exam	$10 Co-pay	Not Covered	One Exam Per 12-Month Period
	Children's glasses	$25 Co-pay	Not Covered	One Prescribed Lenses & Frames in a 12-Month Period

* For more information about limitations and exceptions, see the plan or policy document at www.healthfirstny.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	$25 Co-pay	Not Covered	One Dental Exam & Cleaning Per 6-Month Period

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Routine eye care (Adult)
- Acupuncture
- Hearing Aids
- Dental (Adult)
- Infertility Treatment
- Abortion Services

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New York State Department of Financial Services at 1-800-342-5756 or www.dfs.ny.gov/, HHS, DOL, and/or other applicable agency contact information Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596 or NY State of Health Marketplace at 1-855-355-5777 or www.nystateofhealth.ny.gov .

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

New York State Department of Financial Services
One State Street
New York, NY 10004-1511
800-342-3736

* For more information about limitations and exceptions, see the plan or policy document at www.healthfirstny.org

Additionally, a consumer assistance program can help you file your appeal. Contact: Community Health Advocates
633 Third Ave, 10th FL
New York, NY. 10017
888-614-5400
cha@cssny.org

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-789-3668.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-789-3668.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-855-789-3668.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-789-3668.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	$40

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$14,715

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$3,010
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,070

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	$40

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,906

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,880
Coinsurance	$259
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,194

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	$40

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,471

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,270
Coinsurance	$5
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,275

The plan would be responsible for the other costs of these EXAMPLE covered services