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 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 1-888-250-2220 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care, prenatal care and telemedicine are covered before you meet your deductible</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Individual $2,000 / Family $4,000</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premium, Balance Billing charges and the cost of health care services this plan does not cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.healthfirstny.org">www.healthfirstny.org</a> or call 1-888-250-2220 for a list of network providers.</td>
<td>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 service(such as lab work). Check with your provider before</td>
</tr>
</tbody>
</table>
### Healthfirst: Platinum Leaf Premier

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Coverage Period:** 1/1/20 – 12/31/20

**Coverage for:** ALL Coverage Types | **Plan Type:** HMO

---

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
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<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a healthcare provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10 co-pay</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 co-pay</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>If you have a test</strong></th>
<th><strong>Diagnostic test</strong> (x-ray, blood work)</th>
<th>$10 co-pay when performed in a PCP’s office or $40 co-pay when performed in an outpatient facility</th>
<th>Not Covered</th>
<th>Preauthorization Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$40 co-pay when performed in an outpatient facility</td>
<td>Not Covered</td>
<td>Preauthorization Required</td>
</tr>
</tbody>
</table>

---

*For more information about limitations and exceptions, see the plan or policy document at [www.healthfirstny.org](http://www.healthfirstny.org)*
# Healthfirst: Platinum Leaf Premier

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

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<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td><em>If you need drugs to treat your illness or condition</em></td>
<td>Generic drugs</td>
<td>$5 co-pay/30 day prescription (retail) and $10 co-pay/90 day prescription (mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$50 co-pay/30 day prescription (retail) and $100 co-pay/90 day prescription (mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$85 co-pay/30 day prescription (retail) and $170 co-pay/90 day prescription (mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>$85 co-pay/30 day prescription (retail) and $170 co-pay/90 day prescription (mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td><em>If you have outpatient surgery</em></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100 co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$100 co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td><em>If you need immediate medical attention</em></td>
<td>Emergency room care</td>
<td>$100 co-pay</td>
<td>$100 co-pay</td>
</tr>
<tr>
<td></td>
<td>Emergency medical</td>
<td>$100 co-pay</td>
<td>$100 co-pay</td>
</tr>
</tbody>
</table>

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### Healthfirst: Platinum Leaf Premier

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<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$55 co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$500 co-pay per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$100 co-pay per surgery</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$10 co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$500 co-pay per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Covered in full</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$100 co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$500 co-pay per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>$10 Co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$25 Co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$25 Co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$500 co-pay per admission</td>
<td>Not Covered</td>
</tr>
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# Healthfirst: Platinum Leaf Premier

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

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**Coverage for:** ALL Coverage Types  |  **Plan Type:** HMO

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<tr>
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<td><strong>Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% Coinsurance</td>
<td>Not Covered</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Hospice services</td>
<td>$500 co-pay per admission (inpatient) or $10 Co-pay (outpatient)</td>
<td>Not Covered</td>
<td>Preauthorization Required; 210 days per plan year (inpatient); 5 Visits for Family Bereavement Counseling (outpatient)</td>
</tr>
</tbody>
</table>

### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s eye exam</td>
<td>$10 Co-pay</td>
<td>One Exam Per 12-Month Period</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>10% Coinsurance</td>
<td>One Prescribed Lenses &amp; Frames in a 12-Month Period</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>$10 Co-pay</td>
<td>One Dental Exam &amp; Cleaning Per 6-Month Period</td>
</tr>
</tbody>
</table>

### 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.)**

- Acupuncture
- Cosmetic Surgery
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs
- Routine eye care (Adult)
- Dental (Adult)
- Infertility Treatment
- Abortion Services

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

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Abortion Services

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

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

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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

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 1-888-250-2220
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-250-2220
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-250-2220
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-888-250-2220

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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Healthfirst: Platinum Leaf Premier

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 1/1/20 – 12/31/20

Coverage for: ALL Coverage Types | Plan Type: HMO

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 prenatal 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 $14,288

In this example, Peg would pay:

- Cost Sharing
  - Deductibles $0
  - Copayments $2,000
  - Coinsurance $0

- What isn't covered
  - Limits or exclusions $60

- The total Peg would pay is $2,060

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 $7,896

In this example, Joe would pay:

- Cost Sharing
  - Deductibles $0
  - Copayments $1,605
  - Coinsurance $173

- What isn't covered
  - Limits or exclusions $55

- The total Joe would pay is $1,833

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 $2,422

In this example, Mia would pay:

- Cost Sharing
  - Deductibles $0
  - Copayments $1,060
  - Coinsurance $4

- What isn't covered
  - Limits or exclusions $55

- The total Mia would pay is $1,064

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

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Healthfirst complies with Federal civil rights laws. Healthfirst does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthfirst provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Healthfirst at 1-866-305-0408. For TTY/TDD services, call 1-888-542-3821.

If you believe that Healthfirst has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Healthfirst by:

Mail  
Healthfirst Member Services
P.O. Box 5165
New York, NY 10274-5165

Phone  
1-866-305-0408 (for TTY/TDD services, call 1-888-542-3821)

Fax  
1-212-801-3250

In person  
100 Church Street, New York, NY 10007

Email  
http://healthfirst.org/members/contact/

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web  
Office for Civil Rights Complaint Portal at http://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Mail  
U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

Phone  
1-800-368-1019 (TTY/TDD 800-537-7697)
<table>
<thead>
<tr>
<th>Language</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY/TDD: 1-888-542-3821).</td>
</tr>
<tr>
<td>Arabic</td>
<td>ملاحظة: إذا كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لبكلامك، اتصل برقم 1-866-305-0408 (TTY/TDD: 1-888-867-4132).</td>
</tr>
<tr>
<td>Yiddish</td>
<td>אֶנסמאַ רגעט פאַר איטלִיאַן, אַנדאַפשן פאַר איטלִיאַן פאַרן איילן שטראָקטיקצוֹן פאַר אַנדאַפשן פאַרן איילן שטראָקטיקצוֹן פאַרן איילן שטראָקטיקצוֹן פאַרן איילן שטראָקטיקצוֹן פאַרן איילן שטראָקטיקצוֹן פאַרן איילן שטראָקטיקצוֹן</td>
</tr>
<tr>
<td>Bengali</td>
<td>লক্ষ্য করুনঃ যদি আপনার ভাষা বাংলা, তাহলে নিচের তালিকায় তারা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮৬৬-৩০৫-০৪০ (TTY/TDD: 1-888-542-3821).</td>
</tr>
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