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

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$600** individual/**$1,200** Family for In-Network Providers<br>Does not apply to Prescription Drugs, or preventative care visits or services | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| **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 **$4,000**/<br>Family **$8,000** | 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 1-888-250-2220 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 |




OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

| | | |
|---|---|---|
| **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 after deductible | Not Covered | ----------None---------- |
| | Specialist visit | $40 co-pay after deductible | 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 after deductible when performed in a PCP's office or $40 co-pay after deductible when performed in an outpatient facility | Not Covered | Preauthorization Required |
| | Imaging (CT/PET scans, MRIs) | $40 co-pay after deductible when performed in an outpatient facility | Not Covered | Preauthorization Required |

| 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 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 $25 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 | $35 co-pay/30 day prescription (retail) and $88 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 | $70 co-pay/30 day prescription (retail) and $175 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) |
| | Specialty drugs | $70 co-pay/30 day prescription (retail) and $175 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) | $100 co-pay after deductible | Not Covered | Preauthorization Required |
| | Physician/surgeon fees | $100 co-pay after deductible | 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 | $150 co-pay after deductible | $150 co-pay after deductible | Co-pay / Co-insurance waived if Hospital admission |
| | Emergency medical transportation | $150 co-pay after deductible | $150 co-pay after deductible | ----------None---------- |
| | Urgent care | $60 co-pay after deductible | Not Covered | ----------None---------- |

| 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 have a hospital stay** | Facility fee (e.g., hospital room) | $1,000 co-pay per admission after deductible | Not Covered | Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions |
| | Physician/surgeon fees | $100 co-pay per surgery after deductible | Not Covered | Applies only to surgery performed in a hospital inpatient or hospital outpatient facility setting, including freestanding surgicenters, not to office surgery. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 co-pay after deductible | Not Covered | Preauthorization Required for Select Services |
| | Inpatient services | $1,000 co-pay per admission after deductible | 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 copayment after deductible | Not Covered | Preauthorization Required |
| | Childbirth/delivery facility services | $1,000 copayment after deductible per Admission | Not Covered | Preauthorization Required |
| **If you need help recovering or have other special health needs** | Home health care | $25 Co-pay after deductible | Not Covered | Preauthorization Required. 40 visits per plan year |
| | Rehabilitation services | $30 Co-pay after deductible | Not Covered | Preauthorization Required; 60 visits per condition, per plan year combined therapies |
| | Habilitation services | $30 Co-pay after deductible | Not Covered | Preauthorization Required; 60 visits per condition, per plan year combined therapies |
| | Skilled nursing care | $1,000 co-pay per admission after deductible | Not Covered | Preauthorization Required; 200 days per plan year |
| | Durable medical equipment | 20% Coinsurance after deductible | Not Covered | Preauthorization Required |
| | Hospice services | $1,000 co-pay per | Not Covered | Preauthorization Required; 210 days per |

| 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) | |
| | | admission after deductible (inpatient) or $25 Copayment after deductible (outpatient) | | plan year (inpatient); 5 Visits for Family Bereavement Counseling (outpatient) |
| **If your child needs dental or eye care** | Children's eye exam | $25 Co-pay after deductible | Not Covered | One Exam Per 12-Month Period |
| | Children's glasses | 20% Coinsurance after deductible | Not Covered | One Prescribed Lenses & Frames in a 12-Month Period |
| | Children's dental check-up | $25 Co-pay after deductible | Not Covered | One dental exam and 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.)**

- 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)

**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

**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

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.*

## 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** | **$600** |
| ■ **Specialist *[cost sharing]*** | **$40** |
| ■ **Hospital (facility) *[cost sharing]*** | **$1,000** |
| ■ **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** | **$14,611** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $600 |
| Copayments | $3,400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,060** |

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| ■ **The plan's overall deductible** | **$600** |
| ■ **Specialist *[cost sharing]*** | **$40** |
| ■ **Hospital (facility) *[cost sharing]*** | **$1,000** |
| ■ **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 | $600 |
| Copayments | $1,685 |
| Coinsurance | $346 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$2,686** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| ■ **The plan's overall deductible** | **$600** |
| ■ **Specialist *[cost sharing]*** | **$40** |
| ■ **Hospital (facility) *[cost sharing]*** | **$1,000** |
| ■ **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** | **$2,972** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $408 |
| Copayments | $1,730 |
| Coinsurance | $7 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,145** |

# Notice of Non-Discrimination

**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<br>P.O. Box 5165<br>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<br>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf |
| **Mail** | U.S. Department of Health and Human Services<br>200 Independence Avenue SW.<br>Room 509F, HHH Building<br>Washington, DC 20201<br>Complaint forms are available at<br>http://www.hhs.gov/ocr/office/file/index.html |
| **Phone** | 1-800-368-1019 (TTY/TDD 800-537-7697) |

| | |
|---|---|
| ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | English |
| ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY/TDD: 1-888-867-4132). | Spanish |
| 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | Chinese |
| ملحوظة: إذا كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لك بالمجان. اتصل برقم 1-866-305-0408 (رقم هاتف الصم والبكم TTY/TDD: 1-888-542-3821). | Arabic |
| 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-305-0408 (TTY/TDD: 1-888-542-3821).번으로 전화해 주십시오. | Korean |
| ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | Russian |
| ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | Italian |
| ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | French |
| ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | French Creole |
| אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | Yiddish |
| UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | Polish |
| PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | Tagalog |
| লক্ষ্য করুনঃ যদি আপনিথা বাংলা, ক বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | Bengali |
| KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | Albanian |
| ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | Greek |
| خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-866-305-0408 (TTY/TDD: 1-888-542-3821). | Urdu |