



**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](http://www.healthfirstny.org) or call 1-855-789-3668 to request a copy.


Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$5,000</b> individual/ <b>\$10,000</b> Family for In-Network Providers Does not apply to Prescription Drugs, or preventative care visits or services	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Preventive care and prenatal care are covered before you meet your deductible	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But <a href="#">a copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Individual <b>\$6,550</b> / Family <b>\$13,100</b>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	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 <a href="#">out-of-pocket limit</a> .

# Healthfirst: Bronze Pro Plus EPO

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

Coverage Period: 1/1/18 – 12/31/18  
Coverage for: ALL Coverage Types | Plan Type: EPO

Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.healthfirstny.org">www.healthfirstny.org</a> or call 1-855-789-3668 for a list of <a href="#">network providers</a>	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% coinsurance per visit after deductible	Not Covered	-----None-----
	<a href="#">Specialist</a> visit	20% coinsurance per visit after deductible	Not Covered	-----None-----
	<a href="#">Preventive care/screening/Immunization</a>	No Charge	Not Covered	-----None-----
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance per visit after deductible	Not Covered	Preauthorization Required
	Imaging (CT/PET scans, MRIs)	20% coinsurance per visit after deductible when performed in an outpatient facility	Not Covered	Preauthorization Required

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.healthfirstny.org">www.healthfirstny.org</a>	Generic drugs	20% co-insurance after the deductible	Not Covered	Covers up to a 30-day supply (retail prescription) or up to a 90-day supply (mail order prescription)
	Preferred brand drugs	20% co-insurance after the deductible	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	20% co-insurance after the deductible	Not Covered	Covers up to a 30-day supply (retail prescription) or up to a 90-day supply (mail order prescription)
	<a href="#">Specialty drugs</a>	20% co-insurance after the deductible	Not Covered	Covers up to a 30-day supply (retail prescription) or up to a 90-day supply (mail order prescription)
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not Covered	Preauthorization Required
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	Applies only to surgery performed in a hospital outpatient facility setting, including freestanding surgicenters, not to office surgery.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% coinsurance per visit after deductible	20% coinsurance per visit after deductible	Co-pay / Co-insurance waived if Hospital admission
	<a href="#">Emergency medical transportation</a>	20% coinsurance per occurrence after deductible	20% coinsurance per occurrence after deductible	-----None-----
	<a href="#">Urgent care</a>	20% coinsurance per visit after deductible	Not Covered	-----None-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance per admission after deductible	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	Applies only to surgery performed in a hospital inpatient or hospital outpatient

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				facility setting, including freestanding surgicenters, not to office surgery.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance per visit after deductible	Not Covered	-----None-----
	Inpatient services	20% coinsurance 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	20% coinsurance per admission after deductible	Not Covered	-----None-----
	Childbirth/delivery facility services	20% coinsurance per admission after deductible	Not Covered	Preauthorization Required
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% coinsurance after deductible	Not Covered	Preauthorization Required. 40 visits per plan year
	<a href="#">Rehabilitation services</a>	20% coinsurance after deductible	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies
	<a href="#">Habilitation services</a>	20% coinsurance after deductible	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies
	<a href="#">Skilled nursing care</a>	20% coinsurance per admission after deductible	Not Covered	Preauthorization Required; 200 days per plan year
	<a href="#">Durable medical equipment</a>	20% coinsurance after deductible	Not Covered	Preauthorization Required

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Hospice services</a>	20% coinsurance per admission after deductible (inpatient) or 20% coinsurance after deductible (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 after deductible	Not Covered	One Exam Per 12-Month Period
	Children's glasses	\$25 Co-pay after deductible	Not Covered	One Prescribed Lenses & Frames in a 12-Month Period
	Children's dental check-up	20% coinsurance after deductible	Not Covered	One Dental Exam & Cleaning Per 6-Month Period

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Long Term Care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic Care</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Hearing Aids</li> <li>• Dental (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Abortion Services</li> </ul>

**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/](http://www.dfs.ny.gov/), HHS, DOL, and/or other applicable agency contact information

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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](http://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](http://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](mailto: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, kwijigo holne' 1-855-789-3668.

-----*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](#) \$5,000
- [Specialist](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 20%

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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$4,070
Copayments	\$0
Coinsurance	\$2,480
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,610</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 20%

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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$1,437
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$6,492</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$1,540
Copayments	\$0
Coinsurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,925</b>