Healthfirst: Silver Pro Plus EPO

Coverage Period: 1/1/19 – 12/31/19

Coverage for: ALL Coverage Types | Plan Type: EPO

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**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

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$2,950 individual/$5,900 Family for In-Network Providers Does not apply to Prescription Drugs, or preventative care visits or services</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></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><strong>Are there other deductibles for specific services?</strong></td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>Individual $7,900/ Family $15,800</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></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>
</tbody>
</table>

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Healthfirst: Silver Pro Plus EPO

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

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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.

Do you need a referral to see a specialist? No

You can see the specialist you choose without a referral.

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$35 co-pay per visit not subject to deductible</td>
<td>Not Covered</td>
<td>-------------------None-------------------</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$70 co-pay per visit not subject to deductible</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>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$70 co-pay not subject to deductible when performed in an outpatient facility</td>
<td>Not Covered</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$70 co-pay per visit after deductible</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
# Healthfirst: Silver Pro Plus EPO

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

**Coverage Period:** 1/1/19 – 12/31/19

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

## Common Medical Event

<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><strong>Network Provider</strong></td>
<td><strong>Out-of-Network Provider</strong></td>
<td></td>
</tr>
<tr>
<td><strong>(You will pay the least)</strong></td>
<td><strong>(You will pay the most)</strong></td>
<td></td>
</tr>
</tbody>
</table>

### If you need drugs to treat your illness or condition

More information about [prescription drug coverage](#) is available at [www.healthfirstny.org](http://www.healthfirstny.org)

#### Generic drugs

- **$20 co-pay/30 day prescription (retail) and $40 co-pay/90 day prescription (mail order)**
- **Not Covered**

#### Preferred brand drugs

- **$60 co-pay/30 day prescription (retail) and $120 co-pay/90 day prescription (mail order)**
- **Not Covered**

#### Non-preferred brand drugs

- **$110 co-pay /30 day prescription (retail) and $220 co-pay/90 day prescription (mail order)**
- **Not Covered**

#### Specialty drugs

- **$110 co-pay /30 day prescription (retail) and $220 co-pay/90 day prescription (mail order)**
- **Not Covered**

### If you have outpatient surgery

#### Facility fee (e.g., ambulatory surgery center)

- **40% coinsurance after deductible**
- **Not Covered**

#### Physician/surgeon fees

- **$200 copay after deductible**
- **Not Covered**

#### Emergency room care

- **$600 co-pay per visit after deductible**
- **$600 co-pay per visit after deductible**

Co-pay / Co-insurance waived if Hospital admission

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<th>What You Will Pay</th>
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</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td><strong>Emergency medical transportation</strong></td>
<td>$300 co-pay per occurrence after deductible</td>
<td>$300 co-pay per occurrence after deductible</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td><strong>Urgent care</strong></td>
<td>$70 co-pay per visit not subject to deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td><strong>Facility fee (e.g., hospital room)</strong></td>
<td>40% coinsurance per admission after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td><strong>Physician/surgeon fees</strong></td>
<td>$200 copay after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td><strong>Outpatient services</strong></td>
<td>$35 copay/visit not subject to deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td><strong>Inpatient services</strong></td>
<td>40% coinsurance after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td><strong>Office visits</strong></td>
<td>Covered in Full</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td><strong>Childbirth/delivery professional services</strong></td>
<td>$200 Copayment after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td><strong>Childbirth/delivery facility services</strong></td>
<td>40% coinsurance after deductible per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td><strong>Home health care</strong></td>
<td>$35 Co-pay after deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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### Healthfirst: Silver Pro Plus EPO

**Coverage Period:** 1/1/19 – 12/31/19  
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#### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

**Common Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information**
--- | --- | --- | ---

**If you need help recovering or have other special health needs**

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
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</thead>
<tbody>
<tr>
<td>Rehabilitation services</td>
<td>$70 Co-pay not subject to deductible</td>
<td>Not Covered</td>
<td>Preauthorization Required; 60 visits per condition, per plan year combined therapies</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$70 Co-pay not subject to deductible</td>
<td>Not Covered</td>
<td>Preauthorization Required; 60 visits per condition, per plan year combined therapies</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>40% coinsurance after deductible</td>
<td>Not Covered</td>
<td>Preauthorization Required; 200 days per plan year</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>40% Coinsurance after deductible</td>
<td>Not Covered</td>
<td>Preauthorization Required</td>
</tr>
<tr>
<td>Hospice services</td>
<td>40% coinsurance after deductible (inpatient) or $35 Copayment not subject to deductible (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>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s eye exam</td>
<td>$10 Co-pay not subject to deductible</td>
<td>Not Covered</td>
<td>One Exam Per 12-Month Period</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>$25 Co-pay not subject to deductible</td>
<td>Not Covered</td>
<td>One Prescribed Lenses &amp; Frames in a 12-Month Period</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>$35 Co-pay not subject to deductible</td>
<td>Not Covered</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.)**

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

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

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.

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**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


Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-855-789-3668.

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

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 $2,950
- Specialist [cost sharing] $70
- Hospital (facility) [cost sharing] 40%
- Other [cost sharing] $70

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 $13,579

In this example, Peg would pay:

Cost Sharing

Deductibles $2,950
Copayments $1,366
Coinsurance $3,584

What isn’t covered

Limits or exclusions $60

The total Peg would pay is $6,758

Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible $2,950
- Specialist [cost sharing] $70
- Hospital (facility) [cost sharing] 40%
- Other [cost sharing] $70

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 $9,745

In this example, Joe would pay:

Cost Sharing

Deductibles $1,170
Copayments $3,660
Coinsurance $691

What isn’t covered

Limits or exclusions $55

The total Joe would pay is $4,169

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

- The plan’s overall deductible $2,950
- Specialist [cost sharing] $70
- Hospital (facility) [cost sharing] 40%
- Other [cost sharing] $70

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 $2,889

In this example, Mia would pay:

Cost Sharing

Deductibles $344
Copayments $2,510
Coinsurance $30

What isn’t covered

Limits or exclusions $0

The total Mia would pay is $2,884

The plan would be responsible for the other costs of these EXAMPLE covered services.
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  
https://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  
Complaint forms are available at  

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>Yiddish</td>
<td>אָפּעְמָעְרְקָד: אָוִיב אוּרְקָד אָיִדְיָה, זָעִינָע פָרֵהָארָא פֵאָר אָיִוּרְקָד מִיִּיזֶה יוֹלָךְ פָּרֵי. פָּוָאָטָא. רעְפְט 1-866-305-0408 (TTY/TDD: 1-888-542-3821).</td>
</tr>
<tr>
<td>Bengali</td>
<td>লক্ষ্য করনুঁ যদি আপনাই বাংলা, ক বলতে পারেন, তাহলে নিঃস্বার্থে ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-866-305-0408 (TTY/TDD: 1-888-542-3821).</td>
</tr>
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</table>