




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](http://www.healthfirstny.org) or call 1-888-250-2220 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$4,000</b> individual/ <b>\$8,000</b> Family for In-Network Providers  Does not apply to 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, prenatal care and telemedicine 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>\$7,900</b> / Family <b>\$15,800</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> .
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 1-888-250-2220 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 Copayment	Not Covered	-----None-----
	<a href="#">Specialist</a> visit	50% Coinsurance after deductible	Not Covered	-----None-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No Charge	Not Covered	-----None-----
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	50% Coinsurance after deductible	Not Covered	Preauthorization Required
	Imaging (CT/PET scans, MRIs)	50% Coinsurance after deductible	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)	
<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	\$8 co-pay after deductible/30 day prescription (retail) and \$16 co-pay after deductible/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	\$60 co-pay after deductible/30 day prescription (retail) and \$120 co-pay after deductible/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	\$95 co-pay after deductible/30 day prescription (retail) and \$190 co-pay after deductible/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)
	<a href="#">Specialty drugs</a>	\$95 co-pay after deductible/30 day prescription (retail) and \$190 co-pay after deductible/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)
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance after deductible	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)	
	Physician/surgeon fees	50% 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>	50% Coinsurance after deductible	50% Coinsurance after deductible	Co-pay / Co-insurance waived if Hospital admission
	<a href="#">Emergency medical transportation</a>	50% Coinsurance after deductible	50% Coinsurance after deductible	-----None-----
	<a href="#">Urgent care</a>	50% Coinsurance after deductible	Not Covered	-----None-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	50% Coinsurance after deductible	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
	Physician/surgeon fees	50% Coinsurance 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.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 Copayment	Not Covered	-----None-----
	Inpatient services	50% Coinsurance after deductible	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
<b>If you are pregnant</b>	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	50% Coinsurance after deductible	Not Covered	Preauthorization Required
	Childbirth/delivery facility services	50% Coinsurance after deductible	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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	50% Coinsurance after deductible	Not Covered	Preauthorization Required. 40 visits per plan year
	<a href="#">Rehabilitation services</a>	50% Coinsurance after deductible	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies
	<a href="#">Habilitation services</a>	50% Coinsurance after deductible	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies
	<a href="#">Skilled nursing care</a>	50% Coinsurance after deductible	Not Covered	Preauthorization Required; 200 days per plan year
	<a href="#">Durable medical equipment</a>	50% Coinsurance after deductible	Not Covered	Preauthorization Required
	<a href="#">Hospice services</a>	50% Coinsurance after deductible	Not Covered	Preauthorization Required; 210 days per plan year (inpatient); 5 Visits for Family Bereavement Counseling (outpatient)
<b>If your child needs dental or eye care</b>	Children’s eye exam	50% Coinsurance after deductible	Not Covered	One Exam Per 12-Month Period
	Children’s glasses	50% Coinsurance after deductible	Not Covered	One Prescribed Lenses & Frames in a 12-Month Period
	Children’s dental check-up	50% Coinsurance after deductible	Not Covered	One Dental Exam & Cleaning Per 6-Month Period

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

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

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

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

**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. 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 1-888-250-2220.

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, kwijigo 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](#) \$4,000
- [Specialist \[cost sharing\]](#) 50%
- Hospital (facility) [\[cost sharing\]](#) 50%
- Other [\[cost sharing\]](#) 50%

**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>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,897
Copayments	\$0
Coinsurance	\$5,003
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$7,900</b>

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

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist \[cost sharing\]](#) 50%
- Hospital (facility) [\[cost sharing\]](#) 50%
- Other [\[cost sharing\]](#) 50%

**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>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$4,000
Copayments	\$1,268
Coinsurance	\$1,067
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$6,335</b>

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

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist \[cost sharing\]](#) 50%
- Hospital (facility) [\[cost sharing\]](#) 50%
- Other [\[cost sharing\]](#) 50%

**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>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$963
Copayments	\$0
Coinsurance	\$963
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,925</b>

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:

<b>Mail</b>	Healthfirst Member Services P.O. Box 5165 New York, NY 10274-5165
<b>Phone</b>	1-866-305-0408 (for TTY/TDD services, call 1-888-542-3821)
<b>Fax</b>	1-212-801-3250
<b>In person</b>	100 Church Street, New York, NY 10007
<b>Email</b>	<a href="http://healthfirst.org/members/contact/">http://healthfirst.org/members/contact/</a>

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

<b>Web</b>	Office for Civil Rights Complaint Portal at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>
<b>Mail</b>	U.S. Department of Health and Human Services 200 Independence Avenue SW. Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a>
<b>Phone</b>	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