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.

<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 $5,000/ Family $10,000</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 1-855-789-3668 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 services (such as lab work). Check with your provider before you get services.</td>
</tr>
</tbody>
</table>

HFIC-GSBC-PROPLUS-20  1 of 7
## Healthfirst: Gold Pro Plus EPO

### 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:** EPO

---

**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.**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<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>If you visit a health care provider's office or clinic</strong></td>
<td><strong>Primary care visit to treat an injury or illness</strong></td>
<td>$25 co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist visit</strong></td>
<td>$40 co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td><strong>Preventive care/screening/immunization</strong></td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>$25 co-pay when performed in a PCP's office or $40 co-pay when performed in an outpatient facility</td>
<td>Not Covered Preauthorization Required</td>
</tr>
<tr>
<td></td>
<td><strong>Imaging (CT/PET scans, MRIs)</strong></td>
<td>$40 co-pay when performed in an outpatient facility</td>
<td>Not Covered Preauthorization Required</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td><strong>Generic drugs</strong></td>
<td>$10 co-pay /30 day prescription (retail) and $20 co-pay /90 day prescription (mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.healthfirstny.org">www.healthfirstny.org</a></td>
<td><strong>Preferred brand drugs</strong></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><strong>Non-preferred brand drugs</strong></td>
<td>$85 co-pay /30 day prescription (retail) and $170 co-pay /90 day prescription (mail order)</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see the plan or policy document at www.healthfirstny.org*
**Healthfirst: Gold Pro Plus EPO**

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: EPO

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<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Day prescription (mail order)</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>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$300 copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$100 copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$350 co-pay per visit</td>
<td>$350 co-pay per visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$150 co-pay /occurrence</td>
<td>$150 co-pay/occurrence</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$60 co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$500 copay per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$100 copay</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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## Healthfirst: Gold Pro Plus EPO

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

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<td></td>
<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></td>
<td></td>
<td>$25 copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$500 copay per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Outpatient services</td>
<td>$25 copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$500 copay per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Preauthorization Required for Select Services</td>
<td></td>
</tr>
<tr>
<td></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 copay per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>If you are pregnant</td>
<td>Preauthorization Required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>$25 Co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$40 Co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$40 Co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$500 copay per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>15% Coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>$500 copay per admission (inpatient) or $25 Copay (outpatient)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>If you need help recovering or have other special health needs</td>
<td>Preauthorization Required; 200 days per plan year</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>$10 Co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>$25 Co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>If your child needs dental or eye care</td>
<td>One Exam Per 12-Month Period</td>
<td></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)

*HFIC-GSBC-PROPLUS-20*
## Healthfirst: Gold Pro Plus EPO

### 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:** EPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<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></td>
<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>Children’s dental check-up</td>
<td>$25 Co-pay</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

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

- Bariatric Surgery
- Chiropractic Care
- 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

*For more information about limitations and exceptions, see the plan or policy document at www.healthfirstny.org
Healthfirst: Gold Pro Plus EPO
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

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

* For more information about limitations and exceptions, see the plan or policy document at www.healthfirstny.org
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**: $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**: $13,115

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,310</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0
- The total Peg would pay is: $1,310

---

### 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**: $7,906

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,900</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$259</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0
- The total Joe would pay is: $2,159

---

### 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**: $2,687

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$2,050</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$5</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0
- The total Mia would pay is: $2,055

---

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 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).

**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).


**ملحوظة:** إذا كنت تتحدث العربية، سوف تتوفّر خدمات المساعدة اللغوية لك بالمجان. اتصل برقم 1-866-305-0408 (TTY/TDD: 1-888-542-3821).

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-305-0408 (TTY/TDD: 1-888-542-3821). 변으로 전화해 주십시오.

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-305-0408 (TTY/TDD: 1-888-542-3821).

**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).

**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).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis ed pou lang ki disponib gratis pou ou. Rele 1-866-305-0408 (TTY/TDD: 1-888-542-3821).


**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408 (TTY/TDD: 1-888-542-3821).

**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).

**লাঞ্ছ করঞ্চ যদি আসানিসহ বাংলা, ক বলতে পারেন, তাহলে নিউয়র্ক ভাষা সহায়তা পরিষেবা উপলভ্য আছে। ফোন করুন ১ 866-305-0408 (TTY/TDD: 1-888-542-3821).**

**КУЈДЕС:** Нëسه flitni shqip, për ju ka në dispozicion shërbimë të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-305-0408 (TTY/TDD: 1-888-542-3821).

**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).