



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	Answers	Why This Matters:
What is the overall deductible ?	\$2,600 individual/ \$5,200 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 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 \$7,300 / Family \$14,600	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 .


Healthfirst: Silver Pro 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 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 .

 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	\$35 co-pay per visit not subject to deductible	Not Covered	-----None-----
	Specialist visit	\$70 co-pay per visit not subject to deductible	Not Covered	-----None-----
	Preventive care/screening/immunization	No Charge	Not Covered	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	\$70 co-pay not subject to deductible when performed in an outpatient facility	Not Covered	Preauthorization Required
	Imaging (CT/PET scans, MRIs)	\$70 co-pay per visit after deductible	Not Covered	Preauthorization Required

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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	\$20 co-pay/30 day prescription (retail) and \$40 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	\$60 co-pay/30 day prescription (retail) and \$120 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	\$110 co-pay /30 day prescription (retail) and \$220 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	\$110 co-pay /30 day prescription (retail) and \$220 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)	30% coinsurance after deductible	Not Covered	Preauthorization Required
	Physician/surgeon fees	\$200 copay after deductible	Not Covered	Applies only to surgery performed in a hospital outpatient facility setting, including freestanding surgicenters, not to office surgery.
	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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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency medical transportation	\$300 co-pay per occurrence after deductible	\$300 co-pay per occurrence after deductible	-----None-----
	Urgent care	\$70 co-pay per visit not subject to deductible	Not Covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance per admission after deductible	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
	Physician/surgeon fees	\$200 copay 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	\$35 copay/visit not subject to deductible	Not Covered	-----None-----
	Inpatient services	30% coinsurance 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	\$200 Copayment after deductible	Not Covered	-----None-----
	Childbirth/delivery facility services	30% coinsurance after deductible per admission	Not Covered	Preauthorization Required
	Home health care	\$35 Co-pay after deductible	Not Covered	Preauthorization Required. 40 visits per plan year

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Rehabilitation services	\$70 Co-pay not subject to deductible	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies
	Habilitation services	\$70 Co-pay not subject to deductible	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies
	Skilled nursing care	30% coinsurance after deductible	Not Covered	Preauthorization Required; 200 days per plan year
	Durable medical equipment	30% Coinsurance after deductible	Not Covered	Preauthorization Required
	Hospice services	30% coinsurance after deductible (inpatient) or \$35 Copayment not subject to 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 not subject to deductible	Not Covered	One Exam Per 12-Month Period
	Children's glasses	\$25 Co-pay not subject to deductible	Not Covered	One Prescribed Lenses & Frames in a 12-Month Period
	Children's dental check-up	\$35 Co-pay not subject to deductible	Not Covered	One Dental Exam & 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 .)		
<ul style="list-style-type: none"> • Cosmetic Surgery • Long Term Care • Dental (Adult) 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • Routine foot care • Routine eye care (Adult) • Weight loss programs

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

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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
- Acupuncture
- 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

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](#) \$2,600
- [Specialist](#) [*cost sharing*] \$70
- Hospital (facility) [*cost sharing*] 30%
- 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	\$13,599
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$2,600
Copayments	\$1,410
Coinsurance	\$2,688
<i>What isn't covered</i>	
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](#) \$2,600
- [Specialist](#) [*cost sharing*] \$70
- Hospital (facility) [*cost sharing*] 30%
- 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	\$8,569
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,343
Copayments	\$2,940
Coinsurance	\$518
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$4,856

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

- The [plan's](#) overall [deductible](#) \$2,600
- [Specialist](#) [*cost sharing*] \$70
- Hospital (facility) [*cost sharing*] 30%
- 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	\$2,398
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$352
Copayments	\$1,460
Coinsurance	\$22
<i>What isn't covered</i>	
Limits or exclusions	\$557
The total Mia would pay is	\$2,391

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services