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

<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>$0</td>
<td>See the Common Medical Events chart below for your costs for services this <strong>plan</strong> covers.</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>$2,000</td>
<td>The <strong>out-of-pocket limit</strong> 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 <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.healthfirstny.org">www.healthfirstny.org</a> or call 1-888-250-2220 for a list of network providers.</td>
<td>This <strong>plan</strong> uses a <strong>provider network</strong>. You will pay less if you use a <strong>provider</strong> in the plan’s <strong>network</strong>. You will pay the most if you use an <strong>out-of-network provider</strong>, and you might receive a bill from a <strong>provider</strong> for the difference between the provider’s charge and what your <strong>plan</strong> pays (<strong>balance billing</strong>). Be aware, your <strong>network provider</strong> might use an <strong>out-of-network provider</strong> for some services (such as lab work). Check with your <strong>provider</strong> before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No</td>
<td>You can see the <strong>specialist</strong> you choose without a <strong>referral</strong>.</td>
</tr>
</tbody>
</table>
# Healthfirst: Essential Plan 1

**Coverage Period:** 1/1/20 – 12/31/20

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

**Coverage for:** All Coverage Types | Plan Type: HMO

<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></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least) $15 co-pay</td>
<td>Out-of-Network Provider (You will pay the most) Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25 co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$15 co-pay per visit when performed in a PCP’s office or $25 co-pay per visit when performed in an outpatient facility</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$25 co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$6 co-pay/30 day prescription (retail) and $15 co-pay/90 day prescription (mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$15 co-pay/30 day prescription (retail) and $38 co-pay/90 day prescription (mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$30 co-pay/30 day prescription (retail) and $75 co-pay/90 day prescription (mail order)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>$30 co-pay/30 day prescription (retail) and $75 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](http://www.healthfirstny.org)
# Healthfirst: Essential Plan 1

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

<table>
<thead>
<tr>
<th>Coverage Period: 1/1/20 – 12/31/20</th>
<th>Coverage for: All Coverage Types</th>
<th>Plan Type: HMO</th>
</tr>
</thead>
</table>

### If you have outpatient surgery
- **Facility fee (e.g., ambulatory surgery center)**: $50 co-pay, Not Covered, Preauthorization Required
- **Physician/surgeon fees**: $50 co-pay, Not Covered

### If you need immediate medical attention
- **Emergency room care**: $75 co-pay, $75 Copayment, Co-pay / Co-insurance waived if Hospital admission
- **Emergency medical transportation**: $75 co-pay, $75 Copayment
- **Urgent care**: $25 co-pay, Not Covered

### If you have a hospital stay
- **Facility fee (e.g., hospital room)**: $150 co-pay per Admission, Not Covered, Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
- **Physician/surgeon fees**: $50 co-pay, Not Covered

### If you need mental health, behavioral health, or substance abuse services
- **Outpatient services**: $15 co-pay, Not Covered, Preauthorization Required
- **Inpatient services**: $150 co-pay, Not Covered, Preauthorization Required

### If you are pregnant
- **Office visits**: Covered in Full, Not Covered
- **Childbirth/delivery professional services**: $50 co-pay/visit, Not Covered, Preauthorization Required
- **Childbirth/delivery facility services**: $150 co-pay/admission, Not Covered, Preauthorization Required

### If you need help recovering or have
- **Home health care**: $15 copay/visit, Not Covered, Preauthorization Required. 40 visits per plan year

*For more information about limitations and exceptions, see the plan or policy document at [www.healthfirstny.org](http://www.healthfirstny.org)*
### Healthfirst: Essential Plan 1

**Coverage Period:** 1/1/20 – 12/31/20

**Coverage for:** All Coverage Types | **Plan Type:** HMO

#### Summary of Benefits and Coverage:

What this Plan Covers & What You Pay For Covered Services

<table>
<thead>
<tr>
<th>other special health needs</th>
<th>Rehabilitation services</th>
<th>$15 copay/visit</th>
<th>Not Covered</th>
<th>Preauthorization Required; 60 visits per condition, per plan year combined therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habilitation services</td>
<td>$15 copay/visit</td>
<td>Not Covered</td>
<td>Preauthorization Required; 60 visits per condition, per plan year combined therapies</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>$150 co-pay/admission</td>
<td>Not Covered</td>
<td>Preauthorization Required; 200 days per plan year</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>5% coinsurance</td>
<td>Not Covered</td>
<td>Preauthorization Required</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>$150 co-pay/admission (inpatient) or $15 copay/visit (outpatient)</td>
<td>Not Covered</td>
<td>Preauthorization Required; 210 days per plan year (inpatient); 5 Visits for Family Bereavement Counseling (outpatient)</td>
<td></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.)

- Acupuncture
- Cosmetic Surgery
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Routine eye care (Adult)
- Dental (Adult)
- 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
- Hearing Aids
- 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

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-250-2220.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 [insert 1-888-250-2220].
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijijgo 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: $0
- Specialist [cost sharing]: $25
- Hospital (facility) [cost sharing]: $150
- Other [cost sharing]: $25

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: $13,195

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$899</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered: $60

The total Peg would pay is: $959

**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]: $25
- Hospital (facility) [cost sharing]: $150
- Other [cost sharing]: $25

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: $7,496

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$791</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$86</td>
</tr>
</tbody>
</table>

What isn’t covered: $2

The total Joe would pay is: $933

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

- The plan’s overall deductible: $0
- Specialist [cost sharing]: $25
- Hospital (facility) [cost sharing]: $150
- Other [cost sharing]: $25

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: $2,038

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$525</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2</td>
</tr>
</tbody>
</table>

What isn’t covered: $55

The total Mia would pay is: $527

The plan would be responsible for the other costs of these EXAMPLE covered services.