Coverage Period: 1/1/24 - 12/31/24

Coverage for: All Coverage Types | Plan Type: HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.healthfirst.org</u> or call 1-855-789-3668 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this Plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care, prenatal care and telemedicine are covered before you meet your deductible	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a copayment or coinsurance may apply. For example, this <u>plan</u> covers certain preventive services without cost-sharing and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care- benefits/.
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$200	The <u>out-of-pocket limit</u> 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.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.healthfirst.org</u> or call 1-888-250-2220 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

(DT-OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL-OMB control number: 1210-0147/Expiration date: 5/31/2022)

(HHS-OMB control number: 0938-1146/Expiration date: 10/31/2022)

Coverage Period: 1/1/24 – 12/31/24

Coverage for: All Coverage Types | Plan Type: HMO

	What You Will Pay		Limitations Evacations 2 Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Covered in full	Not Covered	None
	Specialist visit	Covered in full	Not Covered	None
	Preventive care/screening/immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Covered in full	Not Covered	Preauthorization Required
	Imaging (CT/PET scans, MRIs)	Covered in full	Not Covered	Preauthorization Required
If you need drugs to treat your illness or condition More information about prescription drug coverage	Generic drugs	\$1 co-pay/30 day prescription (retail) and \$3 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)
is available at www.healthfirst.org	Preferred brand drugs	\$3 co-pay/30 day prescription (retail) and \$8 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	\$3 co-pay/30 day prescription (retail) and \$8 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	\$3 co-pay/30 day prescription (retail) and \$8 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)

^{*} For more information about limitations and exceptions, see the plan or policy document at www.healthfirst.org

Coverage Period: 1/1/24 – 12/31/24

Coverage for: All Coverage Types | Plan Type: HMO

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered in full	Not Covered	Preauthorization Required	
	Physician/surgeon fees	Covered in full	Not Covered	Applies only to surgery performed in a hospital outpatient facility setting, including freestanding surgicenters, not to office surgery.	
If you need immediate medical attention	Emergency room care	Covered in full	Covered in full	Co-pay / Co-insurance waived if Hospital admission	
	Emergency medical transportation	Covered in full	Covered in full	None	
	<u>Urgent care</u>	Covered in full	Not Covered	None	
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered in full	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions	
	Physician/surgeon fees	Covered in full	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	Covered in full	Not Covered	Preauthorization Required on Select Services	
	Inpatient services	Covered in full	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions	

^{*} For more information about limitations and exceptions, see the plan or policy document at www.healthfirst.org

Coverage Period: 1/1/24 – 12/31/24

Coverage for: All Coverage Types | Plan Type: HMO

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
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	Covered in Full	Not Covered	Preauthorization Required	
	Childbirth/delivery facility services	Covered in Full	Not Covered	Preauthorization Required	
	Home health care	Covered in full	Not Covered	Preauthorization Required. 40 visits per	
If you need help recovering or have other special health needs	Rehabilitation services	Covered in full	Not Covered	Preauthorization Required	
neeus	Habilitation services	Covered in full	Not Covered	Preauthorization Required	
	Skilled nursing care	Covered in full	Not Covered	Preauthorization Required; 200 days per plan year	
	Durable medical equipment	Covered in full	Not Covered	Preauthorization Required	
	Hospice services	Covered in full	Not Covered	Preauthorization Required; 210 days per plan year (inpatient); 5 Visits for Family Bereavement Counseling (outpatient)	
	Eye exam	Covered in full	Not Covered	One Exam Per 12-Month Period	
If your child needs dental or eye care	Glasses	Covered in full	Not Covered	One Prescribed Lenses & Frames in a 12- Month Period. Allowance of up to \$100 towards glasses or contact lenses	
	Dental check-up	Covered in full	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.healthfirst.org

Coverage Period: 1/1/24 - 12/31/24

Coverage for: All Coverage Types | Plan Type: HMO

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 SurgeryLong Term Care

Private-duty nursing

• 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

Routine eye care (Adult)

Infertility Treatment

Chiropractic CareHearing Aids

Dental (Adult)

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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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

^{*} For more information about limitations and exceptions, see the plan or policy document at www.healthfirst.org

Healthfirst: Essential Plan 2

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

Coverage Period: 1/1/24 - 12/31/24

Coverage for: All Coverage Types | Plan Type: HMO

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

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, 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, kwiijigo holne' 1-888-250-2220.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.—

^{*} For more information about limitations and exceptions, see the plan or policy document at www.healthfirst.org

\$12,700

Coverage Period: 1/1/24 - 12/31/24

Coverage for: All Coverage Types | Plan Type: HMO

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$0
Specialist	\$0
Hospital (facility)	\$0
Other	\$0

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

In this example, Peg would pay:		
Cost Sharing		
Deductibles	\$0	
Copayments	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$60	

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	\$0
Hospital (facility)	\$0
Other	\$0

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

Total Example Gost	ψυ,000
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$30
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total ioe would pay is	\$50

\$5,600

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	\$0
Specialist	\$0
Hospital (facility)	\$0
Other	\$0

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)

Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Limits or exclusions

The total Mia would pay is

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	

\$0 \$0



Notice of Non-Discrimination

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 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 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 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 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: 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: 1-888-542-3821).	Chinese
ملحوظة: إذا كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لك بالمجان. اتصل برقم 0408-305-866-1 (TTY: 1-888-542-3821).	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-866-305-0408 (TTY: 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 (ТТҮ: 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: 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: 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: 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: 1-888-542-3821).	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-305-0408 (TTY: 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: 1-888-542-3821).	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃথরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১1-866-305-0408 (TTY: 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: 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: 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 TTY: 1-888-542-3821).	Urdu