



**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](http://www.healthfirstny.org) or call 1-855-789-3668 to request a copy.


Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$4,700</b> individual/ <b>\$9,400</b> 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 <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 <a href="#">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> .

# Healthfirst: Silver 40/75/4700 Pro 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

<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="http://www.healthfirstny.org">www.healthfirstny.org</a> or call 1-855-789-3668 for a list of <a href="#">network providers</a>.</p>	<p>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.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$40 co-pay per visit not subject to deductible	Not Covered	-----None-----
	<a href="#">Specialist</a> visit	\$75 co-pay per visit not subject to deductible	Not Covered	-----None-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No Charge	Not Covered	-----None-----
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$75 co-pay not subject to deductible when performed in an outpatient facility	Not Covered	Preauthorization Required
	Imaging (CT/PET scans, MRIs)	\$75 co-pay per visit not subject deductible	Not Covered	Preauthorization Required

**HFIC-SSBC-40/75/4700PRO-20**

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

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

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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)	
<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	\$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)
	<a href="#">Specialty drugs</a>	\$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)
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	45% 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.
	<a href="#">Emergency room care</a>	\$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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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 immediate medical attention	<a href="#">Emergency medical transportation</a>	\$300 co-pay per occurrence after deductible	\$300 co-pay per occurrence after deductible	-----None-----
	<a href="#">Urgent care</a>	\$75 co-pay per visit not subject to deductible	Not Covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	45% 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	\$40 copay/visit not subject to deductible	Not Covered	Preauthorization Required for Select Services
	Inpatient services	45% 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	Preauthorization Required
	Childbirth/delivery facility services	45% coinsurance after deductible per admission	Not Covered	Preauthorization Required
If you need help recovering or have	<a href="#">Home health care</a>	\$40 Co-pay after deductible	Not Covered	Preauthorization Required. 40 visits per plan year

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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)	
<b>other special health needs</b>	<a href="#">Rehabilitation services</a>	\$75 Co-pay not subject to deductible	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies
	<a href="#">Habilitation services</a>	\$75 Co-pay not subject to deductible	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies
	<a href="#">Skilled nursing care</a>	45% coinsurance after deductible	Not Covered	Preauthorization Required; 200 days per plan year
	<a href="#">Durable medical equipment</a>	45% Coinsurance after deductible	Not Covered	Preauthorization Required
	<a href="#">Hospice services</a>	45% coinsurance after deductible (inpatient) or \$40 Copayment not subject to deductible (outpatient)	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	\$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	\$40 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](#).)

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

## 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 1-855-789-3668

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](#) \$4,700
- [Specialist](#) [*cost sharing*] \$75
- Hospital (facility) [*cost sharing*] 45%
- Other [*cost sharing*] \$75

**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>\$13,630</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$2,518
Copayments	\$1,350
Coinsurance	\$4,032
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,960</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$4,700
- [Specialist](#) [*cost sharing*] \$75
- Hospital (facility) [*cost sharing*] 45%
- Other [*cost sharing*] \$75

**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>\$8,649</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$1,074
Copayments	\$3,070
Coinsurance	\$778
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$4,976</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$4,700
- [Specialist](#) [*cost sharing*] \$75
- Hospital (facility) [*cost sharing*] 45%
- Other [*cost sharing*] \$75

**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>\$3,373</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$490
Copayments	\$2,850
Coinsurance	\$33
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$3,373</b>



**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
אויפּמערקזאַם: אויב איר רעדט אידיש, זענען פאַרהאַן פאַר אייך שפּראַך הילף סערוויסעס פּרײַ פּון 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