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

## Coverage Period: 01/01/2025 - 12/31/2025

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 <u>plan</u> 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 <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	Individual <b>\$2,000/</b> Family <b>\$4,000</b>	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	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</u> provider?	Yes. See <u>www.healthfirst.org</u> or call 1-888-250-2220 for a list of <u>network</u> <u>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 plan's <u>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
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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/Expirationdate: 5/31/2022)

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		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	
	Primary care visit to treat an injury or illness	**\$15 co-pay	Not Covered	In-network primary care visits delivered via Telehealth are subject to \$15 co-pay	
If you visit a health care provider's	Specialist visit	**\$35 co-pay	Not Covered	In-network specialist visits delivered via Telehealth are subject to \$35 co-pay	
office or clinic	Preventive care/screening/immunization	No Charge	Not Covered	None	
If you have a test	Diagnostic test (x-ray, blood work)	**\$15 co-pay when performed in a PCP's office or \$35 co-pay when performed in an outpatient facility/specialist	Not Covered	Preauthorization Required	
	Imaging (CT/PET scans, MRIs)	**\$35 co-pay when performed in an outpatient facility	Not Covered	Preauthorization Required	
If you need drugs to treat your illness or condition	Generic drugs	**\$10 co-pay/30-day prescription (retail) and \$25 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	
More information about prescription drug coverage is available at www.healthfirst.org	Preferred brand drugs	**\$30 co-pay/30-day prescription (retail) and \$75 co-pay/90-day prescription (mail order)	Not Covered	order prescription)  NOTE: Diabetes medication, supplies, equipment, and self- management education are subject to the primary care	
	Non-preferred brand drugs	**\$60 co-pay/30-day prescription (retail) and \$150 co-pay/90-day prescription (mail order)	Not Covered	office visit copayment  **Cost-share is waived if the primary diagnosis is diabetes.	

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at <a href="www.healthfirst.org">www.healthfirst.org</a>

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		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 need drugs to treat your illness or condition (continued)	Specialty drugs	**\$60 co-pay/30-day prescription (retail) and \$150 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)  NOTE: Diabetes medication, supplies, equipment, and self- management education are subject to the primary care office visit copayment
<b>K</b>	Facility fee (e.g., ambulatory surgery center)	\$100 co-pay	Not Covered	Preauthorization Required
If you have outpatient surgery	Physician/surgeon fees	\$100 co-pay	Not Covered	Applies only to surgery performed in a hospital outpatient facility setting, including freestanding surgicenters, not to office surgery.
If you need	Emergency room care	\$100 co-pay	Not Covered	Co-pay / Co-insurance waived if Hospital admission
immediate medical attention	Emergency medical transportation	\$100 co-pay	Not Covered	None
medical attention	Urgent care	**\$55 co-pay	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 co-pay per admission	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
nospital day	Physician/surgeon fees	\$100 co-pay per surgery	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	Outpatient services	\$15 co-pay	Not Covered	Preauthorization Required for Select Services 20 visits per plan year for Family Counseling
health, behavioral health, or substance abuse services	Inpatient services	\$500 co-pay per admission	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at www.healthfirst.org

<sup>\*\*</sup>Cost-share is waived if the primary diagnosis is diabetes.

		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	\$100 co-pay	Not Covered	Preauthorization Required	
	Childbirth/delivery facility services	\$500 co-pay	Not Covered	Preauthorization Required	
	Home health care	\$15 co-pay	Not Covered	Preauthorization Required. 40 visits per plan year	
	Rehabilitation services	\$25 co-pay	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies	
If you need help recovering or have	<u>Habilitation services</u>	\$25 co-pay	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies	
other special health needs	Skilled nursing care	\$500 co-pay per admission	Not Covered	Preauthorization Required; 200 days per plan year	
	<u>Durable medical equipment</u>	**10% co-insurance	Not Covered	Preauthorization Required	
	Hospice services	\$500 co-pay per admission (Inpatient) or \$15 co-pay (Outpatient)	Not Covered	Preauthorization Required; 210 days per plan year (inpatient); 5 Visits for Family Bereavement Counseling (outpatient)	
	Children's eye exam	\$15 co-pay	Not Covered	One Exam Per 12-Month Period	
If your child needs dental or eye care	Children's glasses	10% co-insurance	Not Covered	One Prescribed Lenses & Frames in a 12 Month Period. \$100 Annual Allowance towards purchase of frames or contact lenses	
	Children's dental check-up	\$15 co-pay	Not Covered	One Dental Exam & Cleaning Per 6-Month Period	

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at www.healthfirst.org

<sup>\*\*</sup>Cost-share is waived if the primary diagnosis is diabetes

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#### **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
- Weight loss programs
- Routine eye care (Adult)
- Dental (Adult)

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

Bariatric Surgery

• Infertility Treatment

Chiropractic Care

Abortion Services

Hearing Aids

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

<sup>\*</sup> For more information about limitations and exceptions, see the plan or policy document at <a href="www.healthfirst.org">www.healthfirst.org</a>

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### Does this plan provide Minimum Essential Coverage? Yes

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

#### 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.

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' 1-855-789-3668.

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

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## **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	\$35
■ Hospital (facility)	\$500
Other	\$35

## 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	\$35
<ul><li>Hospital (facility)</li></ul>	\$500
Other	\$35

## **Mia's Simple Fracture**

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ Specialist	\$35
■ Hospital (facility)	\$500
■ Other	\$35

#### 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 (apesthesia)

Specialist visit (anesthesia)	
Total Example Cost	\$12,700

Total Example 500t		
In this example, Peg would pay:		
Cost Sharing		
Deductibles	\$0	
Copayments	\$1,000	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$2,700	
The total Peg would pay is	\$3,700	

#### This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

The total Joe would pay is

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$80
What isn't covere	ed
Limits or exclusions	\$20

#### 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	\$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$820

\$500



# 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 has 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: Visit a Healthfirst Community Office. Locations and hours are available at Healthfirst.org/CommunityOffices

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