



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.healthfirstny.org](http://www.healthfirstny.org) or by calling 1-855-789-3668.

Important Questions	Answers	Why this Matters:
What is the overall <b>deductible</b> ?	\$0	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b>
Are there other <b>deductibles</b> for specific services?	No	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers
Is there an <b>out-of-pocket limit</b> on my expenses?	Yes. Individual <b>\$2,000</b> / Family <b>\$4,000</b>	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <b>out-of-pocket limit</b> ?	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 <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of <b>In-Network providers</b> , see <a href="http://www.healthfirstny.org">www.healthfirstny.org</a> or call 1-855-789-3668.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No	You can see the <b>specialist</b> you choose without a <b>referral</b> .
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <b>excluded services</b> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay per visit	Not Covered	-----None-----
	Specialist visit	\$35 co-pay per visit	Not Covered	-----None-----
	Other practitioner office visit	\$20 co-pay per visit (Nurse Practitioners and Physician Assistants) and \$35 co-pay per visit (Chiropractor)	Not Covered	-----None-----
	Preventive care/screening/immunization	No Charge	Not Covered	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	\$20 co-pay per visit when performed in a PCP's office or \$35 co-pay per visit when performed in an outpatient facility	Not Covered	Preauthorization Required

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# Healthfirst: Platinum Pro EPO

Coverage Period: 1/1/17 – 12/31/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Types | Plan Type: EPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	\$35 co-pay per visit when performed in an outpatient facility	Not Covered	Preauthorization Required
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.healthfirstny.org">www.healthfirstny.org</a> .	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 order prescription)
	Preferred brand drugs	\$50 co-pay /30 day prescription (retail) and \$125 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	50% coinsurance up to \$500 /30 day prescription (retail) and 50% coinsurance up to \$1,250 /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)

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	Specialty drugs	50% coinsurance up to \$500 /30 day prescription (retail) and 50% coinsurance up to \$1,250 /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)	\$200 copay	Not Covered	Preauthorization Required
	Physician/surgeon fees	\$100 copay	Not Covered	Applies only to surgery performed in a hospital outpatient facility setting, including freestanding surgicenters, not to office surgery.
<b>If you need immediate medical attention</b>	Emergency room services	\$250 co-pay per visit	\$250 co-pay per visit	Co-pay / Co-insurance waived if Hospital admission
	Emergency medical transportation	\$150 co-pay per visit	\$150 co-pay per visit	-----None-----
	Urgent care	\$50 co-pay per visit	Not Covered	-----None-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$500 copay per admission	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
	Physician/surgeon fee	\$100 copay	Not Covered	Applies only to surgery performed in a hospital inpatient or hospital outpatient facility setting, including freestanding surgicenters, not to office surgery.

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<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$20 co-pay per visit	Not Covered	-----None-----
	Mental/Behavioral health inpatient services	\$500 copay per admission	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
	Substance use disorder outpatient services	\$20 co-pay per visit	Not Covered	-----None-----
	Substance use disorder inpatient services	\$500 copay per admission	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
<b>If you are pregnant</b>	Prenatal and postnatal care	Covered in Full	Not Covered	-----None-----
	Delivery and all inpatient services	\$500 copay per admission	Not Covered	Preauthorization Required
<b>If you need help recovering or have other special health needs</b>	Home health care	\$20 Co-pay	Not Covered	Preauthorization Required
	Rehabilitation services	\$35 Co-pay	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies
	Habilitation services	\$35 Co-pay	Not Covered	Preauthorization Required; 60 visits per condition, per plan year combined therapies
	Skilled nursing care	\$500 copay per admission	Not Covered	Preauthorization Required; 200 days per plan year
	Durable medical equipment	15% Coinsurance	Not Covered	Preauthorization Required
	Hospice service	\$500 copay per admission (inpatient) or \$20 Copayment (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>	Eye exam	\$10 Co-pay	Not Covered	One Exam Per 12-Month Period
	Glasses	\$25 Co-pay	Not Covered	One Prescribed Lenses & Frames in a 12-Month Period

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Dental check-up	\$20 Co-pay	Not Covered	One Dental Exam & Cleaning Per 6-Month Period

## Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)			
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>	

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**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Abortion Services

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-789-3668. You may also contact your state insurance department, the New York State Department of Financial Services, at 800-342-3736.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can 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  
105 East 22nd Street  
New York, NY. 10011

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888-614-5400

cha@cssny.org

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 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.

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

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,050
- Patient pays \$1,490

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$510
Copays	\$830
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,490</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,580
- Patient pays \$820

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$10
Copays	\$540
Coinsurance	\$190
Limits or exclusions	\$80
<b>Total</b>	<b>\$820</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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