# Healthfirst: Gold 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

**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 or by calling 1-855-789-3668.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,000** individual/**$2,000** Family for In-Network Providers<br>Does not apply to Prescription Drugs, or preventative care visits or services | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible** |
| **Are there other deductibles for specific services?** | **No** | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers |
| **Is there an out–of–pocket limit on my expenses?** | **Yes.** Individual **$3,500/** Family **$7,000** | The **out-of-pocket limit** 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 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**. |
| **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 *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of **In-Network providers**, see www.healthfirstny.org or call 1-855-789-3668. | If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers.** |
| **Do I need a referral to see a specialist?** | No | You can see the **specialist** you choose without a **referral**. |
| **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 **excluded services**. |

**Questions:** Call 1-855-789-3668 or visit us at **www.healthfirstny.org**.
This plan's subscriber contract is available at http://www.healthfirst.org/members/plan-materials/2017-hfic-small-group
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-855-789-3668 to request a copy.

- **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 provider's office or clinic** | Primary care visit to treat an injury or illness | $25 co-pay per visit not subject to deductible | Not Covered | --------------------None--------------------- |
| | Specialist visit | $40 co-pay per visit not subject to deductible | Not Covered | --------------------None--------------------- |
| | Other practitioner office visit | $25 co-pay per visit not subject to deductible (Nurse Practitioners and Physician Assistants) and $40 co-pay per visit not subject to deductible (Chiropractor) | Not Covered | --------------------None--------------------- |
| | Preventive care/screening/immunization | No Charge | Not Covered | --------------------None--------------------- |

| 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 have a test** | Diagnostic test (x-ray, blood work) | $25 co-pay per visit not subject to deductible when performed in a PCP's office or $40 co-pay per visit not subject to deductible when performed in an outpatient facility | Not Covered | Preauthorization Required |
| | Imaging (CT/PET scans, MRIs) | $40 co-pay per visit after deductible when performed in an outpatient facility | Not Covered | Preauthorization Required |

| 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 need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.healthfirstny.org. | Generic drugs | $20 co-pay not subject to deductible/30 day prescription (retail) and $50 co-pay not subject to deductible /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 not subject to deductible /30 day prescription (retail) and $125 co-pay not subject to deductible /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 not subject to deductible /30 day prescription (retail) and 50% coinsurance up to $1,250 not subject to deductible /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) |

| 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 |
|---|---|---|---|---|
| | Specialty drugs | 50% coinsurance up to $500 not subject to deductible /30 day prescription (retail) and 50% coinsurance up to $1,250 not subject to deductible /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) |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | Not Covered | Preauthorization Required |
| | Physician/surgeon fees | $100 copay after deductible | 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 services | $300 co-pay per visit after deductible | $300 co-pay per visit after deductible | Co-pay / Co-insurance waived if Hospital admission |
| | Emergency medical transportation | $150 co-pay per visit after deductible | $150 co-pay per visit after deductible | --------------------None--------------------- |
| | Urgent care | $60 co-pay per visit not subject to deductible | Not Covered | --------------------None--------------------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance per admission after deductible | Not Covered | Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions |

| 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 |
|---|---|---|---|---|
| | Physician/surgeon fee | $100 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 have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $25 co-pay per visit not subject to deductible | Not Covered | --------------------None-------------------- |
| | Mental/Behavioral health inpatient services | 20% coinsurance per admission after deductible | Not Covered | Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions |
| | Substance use disorder outpatient services | $25 co-pay per visit not subject to deductible | Not Covered | --------------------None-------------------- |
| | Substance use disorder inpatient services | 20% coinsurance per admission after deductible | Not Covered | Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions |
| **If you are pregnant** | Prenatal and postnatal care | Covered in Full | Not Covered | --------------------None-------------------- |
| | Delivery and all inpatient services | 20% coinsurance per admission after deductible | Not Covered | Preauthorization Required |

| 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 need help recovering or have other special health needs** | Home health care | $25 Co-pay after deductible | Not Covered | Preauthorization Required |
| | Rehabilitation services | $40 Co-pay not subject to deductible | Not Covered | Preauthorization Required; 60 visits per condition, per plan year combined therapies |
| | Habilitation services | $40 Co-pay not subject to deductible | Not Covered | Preauthorization Required; 60 visits per condition, per plan year combined therapies |
| | Skilled nursing care | 20% coinsurance per admission after deductible | Not Covered | Preauthorization Required; 200 days per plan year |
| | Durable medical equipment | 20% Coinsurance after deductible | Not Covered | Preauthorization Required |
| | Hospice service | 20% coinsurance per admission after deductible (inpatient) or $25 Copayment not subject to deductible (outpatient) | Not Covered | Preauthorization Required; 210 days per plan year (inpatient); 5 Visits for Family Bereavement Counseling (outpatient) |
| **If your child needs dental or eye care** | Eye exam | $10 Co-pay not subject to deductible | Not Covered | One Exam Per 12-Month Period |
| | Glasses | $25 Co-pay not subject to deductible | Not Covered | One Prescribed Lenses & Frames in a 12-Month Period |
| | Dental check-up | $25 Co-pay not subject to deductible | 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 excluded services.)**

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

**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
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.*

## 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** $5,190
- **Patient pays** $2,350

**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 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,020 |
| Copays | $290 |
| Coinsurance | $890 |
| Limits or exclusions | $150 |
| **Total** | **$2,350** |

## Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,250
- **Patient pays** $2,150

**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 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,020 |
| Copays | $800 |
| Coinsurance | $250 |
| Limits or exclusions | $80 |
| **Total** | **$2,150** |

## 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.