



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 1-888-250-2220.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
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 <u>out-of-pocket limit</u> on my expenses?	Yes. Individual \$2,000 /Family \$4,000	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 <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 .
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 <u>network of providers</u> ?	Yes. For a list of In-Network providers , see www.healthfirstny.org or call 1-888-250-2220.	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 <u>specialist</u> ?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .



- **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

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Healthfirst: Platinum Leaf

Coverage Period: 1/1/14 – 12/31/14

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

Coverage for: All Coverage Types | Plan Type: HMO

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	\$15 co-pay per visit after deductible	Not Covered	-----None-----
	Specialist visit	\$35 co-pay per visit after deductible	Not Covered	-----None-----
	Other practitioner office visit	\$15 co-pay per visit after deductible (Nurse Practitioners and Physician Assistants) and \$35 co-pay per visit after deductible (Chiropractor)	Not Covered	-----None-----
	Preventive care/screening/immunization	No Charge	Not Covered	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	\$15 co-pay per visit after deductible when performed in a PCP's office or \$35 co-pay per visit after deductible when performed in an outpatient facility	Not Covered	-----None-----

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	Imaging (CT/PET scans, MRIs)	\$15 co-pay per visit after deductible when performed in a PCP's office or \$35 co-pay per visit after deductible when performed in an outpatient facility	Not Covered	-----None-----
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.healthfirstny.org.</p>	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	\$30 co-pay/30 day prescription (retail) and \$75 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	\$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)
	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)

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 co-pay after deductible	Not Covered	Preauthorization Required
	Physician/surgeon fees	\$100 co-pay 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	\$100 co-pay per visit after deductible	\$100 co-pay per visit after deductible	Co-pay / Co-insurance waived if Hospital admission
	Emergency medical transportation	\$100 co-pay per visit after deductible	\$100 co-pay per visit after deductible	-----None-----
	Urgent care	\$55 co-pay per visit after deductible	Not Covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 co-pay per admission after deductible	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
	Physician/surgeon fee	\$100 co-pay per surgery 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.

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 co-pay per visit after deductible	Not Covered	Preauthorization Required
	Mental/Behavioral health inpatient services	\$500 co-pay per admission after deductible	Not Covered	Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions
	Substance use disorder outpatient services	\$15 co-pay per visit after deductible	Not Covered	Preauthorization Required; Unlimited; Up to 20 Visits a Plan Year May Be Used For Family Counseling
	Substance use disorder inpatient services	\$500 co-pay 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	Preauthorization Required
	Delivery and all inpatient services	\$500 co-pay per admission after deductible	Not Covered	Preauthorization Required

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If you need help recovering or have other special health needs	Home health care	\$15 Co-pay after deductible	Not Covered	Preauthorization Required
	Rehabilitation services	\$25 Co-pay after deductible	Not Covered	Preauthorization Required; 60 visits per condition, per lifetime combined therapies
	Habilitation services	\$25 Co-pay after deductible	Not Covered	Preauthorization Required
	Skilled nursing care	\$500 co-pay per admission after deductible	Not Covered	Preauthorization Required; 200 days per plan year
	Durable medical equipment	10% Coinsurance after deductible	Not Covered	Preauthorization Required
	Hospice service	\$500 co-pay per admission after deductible (inpatient) or \$15 Copayment after 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	\$15 Co-pay after deductible	Not Covered	One Exam Per 12-Month Period
	Glasses	10% Coinsurance after deductible	Not Covered	One Prescribed Lenses & Frames in a 12-Month Period
	Dental check-up	Not Covered	Not Covered	-----None-----

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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.)

- Acupuncture
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment

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 1-888-250-2220. You may also contact your state insurance department, the New York State Department of Financial Services, at 800-342-3736.

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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 1-888-250-2220.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-250-2220.

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 \$6,450
- Patient pays \$1,090

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	\$0
Copays	\$940
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$1,090

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

- Amount owed to providers: \$5,400
- Plan pays \$4,500
- Patient pays \$900

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	\$0
Copays	\$690
Coinsurance	\$130
Limits or exclusions	\$80
Total	\$900

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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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