

Primary Select Platinum Plan: Health Republic Insurance of New York Coverage Period: 01/01/2015 – 12/31/2015
Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual & Family | 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 by calling 1-888-990-5702.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	<p>\$0/ person \$0/family</p> <p>Benefits not subject to deductible include: preventive care, PCP, Specialist & other practitioner visits, generic prescription drugs, diagnostic tests, and imaging.</p>	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see 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. \$1,400 / person \$2,800 / family	The <u>out-of-pocket limit</u> 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>?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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. See http://healthrepublicny.org/for-members/find-a-provider/ or call 1-888-990-5702 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

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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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$0 copay/visit	Not covered	_____none_____
	Specialist visit	\$75 copay/visit	Not covered	_____none_____
	Other practitioner office visit	\$15 copay/visit	Not covered	_____none_____
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	\$75 copay/visit	Not covered	_____none_____
	Imaging (CT/PET scans, MRIs)	\$75 copay/visit	Not covered	_____none_____

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://healthrepublicny.org	Selected generic drugs	Retail: \$0.copay/prescription Mail order: \$25 copay/prescription.	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Preferred brand drugs	Retail: \$30 copay/prescription Mail order: \$75 copay/prescription.	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Non-preferred brand drugs	Retail: \$60 copay/prescription Mail order: \$150 copay/prescription.	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
	Specialty drugs	Retail: \$70 copay/prescription Mail order: \$175 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance.	Not covered	_____none_____
	Physician/surgeon fees	20% coinsurance .	Not covered	_____none_____
If you need immediate medical attention	Emergency room services	\$250 copay/visit.	\$250 copay/visit	_____none_____
	Emergency medical transportation	\$100 copay/visit .	\$100 copay/visit	_____none_____
	Urgent care	\$100 copay/visit.	Not covered	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance.	Not covered	_____none_____
	Physician/surgeon fee	\$100 copay/case	Not covered	_____none_____

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$0 copay/visit.	Not covered	—————none—————
	Mental/Behavioral health inpatient services	20% coinsurance.	Not covered	—————none—————
	Substance use disorder outpatient services	\$0 copay/visit.	Not covered	—————none—————
	Substance use disorder inpatient services	20% coinsurance.	Not covered	—————none—————
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	—————none—————
	Delivery and all inpatient services	20% coinsurance.	Not covered	—————none—————
If you need help recovering or have other special health needs	Home health care	\$15 copay/visit.	Not covered	40 visits per year
	Rehabilitation services	\$30 copay/visit	Not covered	60 visits per condition per lifetime
	Habilitation services	\$30 copay/visit	Not covered	60 visits per condition per lifetime
	Skilled nursing care	20% coinsurance.	Not covered	200 days per year
	Durable medical equipment	20% cost-sharing.	Not covered	\$1,500 per year
	Hospice service	Inpatient: 20% coinsurance . Outpatient: \$15 copay/visit.	Not covered	210 days per year
If your child needs dental or eye care	Eye exam	\$15 copay/visit	Not covered	Limited to one eye exam per 12 months
	Glasses	20% coinsurance.	Not covered	Limited to one pair of glasses per year
	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.)

- | | | |
|-----------------------|------------------------------------------------------|----------------------------|
| • Cosmetic surgery | • Long-term care | • Private-duty nursing |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) |
| | | • Routine foot care |

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 | • Hearing aids | • Weight loss programs |
| • Bariatric surgery | • Infertility treatments | |
| • Chiropractic care | | |

Your Rights to Continue Coverage:

Individual health insurance

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 **1-888-990-5702**. You may also contact your state insurance department at www.dfs.ny.gov.

Language Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-888-990-5702.

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: 1-800-342-3736.

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.**

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 \$5,990
- Patient pays \$1,550

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	\$620
Coinsurance	\$780
Limits or exclusions	\$150
Total	\$1,550

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

- Amount owed to providers: \$5,400
- Plan pays \$4,210
- Patient pays \$1,190

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	\$860
Coinsurance	\$250
Limits or exclusions	\$80
Total	\$1,190

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-888-990-5702.

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Questions and answers about the Coverage:

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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