Version Updated: 10/28/2021

Rating Region: Rochester

	Healthy New York EPO		Healthy New York EPO	
Plan Overview				
Plan ID	78124NY1110009-00		78124NY1110009-00 (SYI7)	
Plan Name	Healthy New York EPO		Healthy New York EPO	
Aggregation Design	Individual Aggregation		Individual Aggregation	
Plan Highlights	A deductible is applied to all covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full. Plan includes ExerciseRewards.		A deductible is applied to all covered medical benefits, prescription drugs are not subject to the deductible. Preventive services are covered in full. Plan includes Active&Fit ExerciseRewards.	
Plan Type	Hybrid		Hybrid	
HSA Eligible	No		No	
Quote Effective	04/01/2021 - 06/30/2021		04/01/2022 - 06/30/2022	
Rate ($)	**Small Group**		**Small Group**	
Single	$368.15		$400.80	
Subscriber & Spouse	$736.30		$801.60	
Subscriber & Child(ren)	$625.86		$681.36	
Family	$1,049.23		$1,142.28	
Plan features				
Primary Care Physician (PCP)	Not Required		Not Required	
Referrals	Not Required		Not Required	
Out of network benefits	Not Covered		Not Covered	
Out of area benefits	Coverage provided worldwide through our BlueCardÂ® Network		Coverage provided worldwide through our BlueCard Network	
Student/Dependent coverage	Qualified dependents are covered to age 26		Qualified dependents are covered to age 26	
Domestic partner	Covered		Covered	
Wellness Incentives	ExerciseRewardsÃ‚Â® receive up to $600 in rewards a year by visiting a qualified fitness facility and save on Gym memberships with Active&Fit DirectÃ¢â€žÂ¢.		Active&Fit ExerciseRewards receive up to $600 in rewards a year by visiting a qualified fitness facility or by tracking your steps using a wearable device. Save on Gym memberships with Active&Fit Direct.	
Plan cost-sharing highlights				
Plan cost-sharing highlights	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**

	Healthy New York EPO		Healthy New York EPO	
Primary Care Office Visit	$25 copay per visit, subject to deductible	Not Covered	$25 copay per visit, subject to deductible	Not Covered
Specialist Office Visit	$40 copay per visit, subject to deductible	Not Covered	$40 copay per visit, subject to deductible	Not Covered
Coinsurance	Covered at 100%	Not Covered	Covered at 100%	Not Covered
Deductible	In-Network: $600 Individual / $1,200 Family	Not Covered	In-Network: $600 Individual / $1,200 Family	Not Covered
Out of pocket maximum	In-Network: $4,000 Individual / $8,000 Family	Not Covered	$4,000 Individual / $8,000 Family	Not Covered
Lifetime maximum	None	None	None	None
Plan Benefits				
Preventive Healthcare Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Well child visits	Covered In Full	Not Covered	Covered In Full	Not Covered
Adult routine physical exams	Covered In Full	Not Covered	Covered In Full	Not Covered
+Adult immunizations	Covered In Full	Not Covered	Covered In Full	Not Covered
+Mammography	Covered In Full	Not Covered	Covered In Full	Not Covered
+Pap smear	Covered In Full	Not Covered	Covered In Full	Not Covered
Routine GYN Exam	Covered In Full	Not Covered	Covered In Full	Not Covered
+Prostate cancer screening	Covered In Full	Not Covered	Covered In Full	Not Covered
+Colonoscopy	Preventive screenings covered in full	Not Covered	Preventive screenings covered in full	Not Covered
+Family Planning Services	Covered in full	Not Covered	Covered In Full	Not Covered
Physician Office Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic office visits	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Telemedicine and Telehealth Services	Covered in full, subject to the deductible	Covered at 100%, subject to the deductible	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible
Diagnostic x-rays	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Advanced Imaging Services	$40 copay per visit, subject to the deductible	Not Covered	$40 copay per visit, subject to the deductible	Not Covered
Diagnostic laboratory and pathology	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Allergy tests	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Allergy injections	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Chemotherapy	$25 PCP copay per visit, subject to deductible	Not Covered	$25 PCP copay per visit, subject to deductible	Not Covered
Radiation therapy	$25 PCP copay per visit, subject to deductible	Not Covered	$25 PCP copay per visit, subject to deductible	Not Covered
Maternity Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prenatal care	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Not Covered	Covered in full (Cost share may apply to ultrasounds, lab work and sick visits)	Not Covered
Hospital care for mom	Subject to $1,000 copay per admission,	Not Covered	Subject to $1,000 copay per admission,	Not Covered

	Healthy New York EPO		Healthy New York EPO	
(including delivery)	subject to the deductible		subject to the deductible	
Newborn nursery care	Covered In Full, subject to deductible	Not Covered	Covered In Full, subject to deductible	Not Covered
Prescription Drug	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prescription Drug Coverage	$10/$35/$70	Not Covered	$10/$35/$70	Not Covered
Diabetic drugs, insulin, and supplies	$25 copay, subject to deductible per 30 day supply	Not Covered	$25 copay, subject to deductible per 30 day supply	Not Covered
Inpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospital benefits	Subject to $1,000 copay per admission for unlimited days, subject to the deductible	Not Covered	Subject to $1,000 copay per admission for unlimited days, subject to the deductible	Not Covered
Physician visits in the hospital	Covered In Full	Not Covered	Covered In Full	Not Covered
Inpatient physical rehabilitation	Subject to $1,000 copay per admission for up to 60 days per contract year, subject to the deductible	Not Covered	Subject to $1,000 copay per admission for up to 60 days per contract year, subject to the deductible	Not Covered
Surgery	$100 copay per visit, subject to deductible	Not Covered	$100 copay per visit, subject to deductible	Not Covered
Anesthesia	Covered In Full	Not Covered	Covered In Full	Not Covered
Emergency Care	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency room care	$150 copay per visit, subject to deductible	$150 copay per visit, subject to deductible	$150 copay per visit, subject to deductible	$150 copay per visit, subject to deductible
Freestanding urgent care center	$60 copay per visit, subject to deductible	Not Covered	$60 copay per visit, subject to deductible	Not Covered
Ambulance	$150 copay per visit, subject to deductible	$150 copay per visit, subject to deductible	$150 copay per visit, subject to deductible	$150 copay per visit, subject to deductible
Outpatient Hospital Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Diagnostic x-rays	$40 copay per visit, subject to the deductible	Not Covered	$40 copay per visit, subject to the deductible	Not Covered
Advanced Imaging Services	$40 copay per visit, subject to the deductible	Not Covered	$40 copay per visit, subject to the deductible	Not Covered
Diagnostic laboratory and pathology	$40 copay per visit, subject to the deductible	Not Covered	$40 copay per visit, subject to the deductible	Not Covered
Surgical Care Facility Fee	$100 copay per visit; subject to deductible	Not Covered	$100 copay per visit; subject to deductible	Not Covered
Chemotherapy	$25 copay per visit, subject to the deductible	Not Covered	$25 copay per visit, subject to the deductible	Not Covered
Radiation Therapy	$25 copay per visit, subject to the deductible	Not Covered	$25 copay per visit, subject to the deductible	Not Covered
Mental Health and Substance Use	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Inpatient mental health care	Subject to $1,000 copay per admission for unlimited days, subject to the deductible	Not Covered	Subject to $1,000 copay per admission for unlimited days, subject to the deductible	Not Covered
Outpatient mental health care	$25 copay per visit, subject to the deductible	Not Covered	$25 copay per visit, subject to the deductible	Not Covered
Inpatient substance use	Subject to $1,000 copay per admission for unlimited days, subject to the deductible	Not Covered	Subject to $1,000 copay per admission for unlimited days, subject to the deductible	Not Covered
Outpatient substance use	$25 copay per visit, subject to the deductible	Not Covered	$25 copay per visit, subject to the deductible	Not Covered
Other Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**

	Healthy New York EPO		Healthy New York EPO	
Skilled nursing facility	Subject to $1,000 copay per admission for up to 200 days per year, subject to the deductible	Not Covered	Subject to $1,000 copay per admission for up to 200 days per year, subject to the deductible	Not Covered
Home care	$25 copay per visit for 40 visits per year, subject to the deductible	Not Covered	$25 copay per visit for 40 visits per year, subject to the deductible	Not Covered
Hospice	Subject to $1,000 copay per admission for up to 210 days per year, subject to the deductible	Not Covered	Subject to $1,000 copay per admission for up to 210 days per year, subject to the deductible	Not Covered
Outpatient therapy	$30 per visit, subject to deductible for physical, speech and occupational therapy for up to 60 visits per contract year	Not Covered	$30 per visit, subject to deductible for physical, speech and occupational therapy for up to 60 visits per contract year	Not Covered
Durable medical equipment	Covered at 80%, subject to the deductible	Not Covered	Covered at 80%, subject to the deductible	Not Covered
External prosthetics	Covered at 80%, subject to the deductible	Not Covered	Covered at 80%, subject to the deductible	Not Covered
Chiropractic	$40 Specialist copay per visit, subject to deductible	Not Covered	$40 Specialist copay per visit, subject to deductible	Not Covered
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Aids	Covered at 80% , subject to the deductible for a single purchase once every 3 years	Not Covered	Covered at 80% , subject to the deductible for a single purchase once every 3 years	Not Covered
Vision Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Routine Vision Exam	Not Covered	Not Covered	Not Covered	Not Covered
Adult Diagnostic Vision	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered	$25 PCP copay; $40 Specialist copay per visit, subject to deductible	Not Covered
Adult Eyewear	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Routine Vision Exam	$25 copay per visit for one routine exam every year, subject to the deductible	Not Covered	$25 copay per visit for one routine exam every year, subject to the deductible	Not Covered
Pediatric Eyewear	Covered at 80%, subject to the deductible for one purchase per plan year	Not Covered	Covered at 80%, subject to the deductible for one purchase per plan year	Not Covered
Dental Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Adult Dental Care	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	$25 per visit, subject to deductible	Not Covered	$25 per visit, subject to deductible	Not Covered
Pediatric Major Dental Care & Medical Ortho	$25 per visit, subject to deductible	Not Covered	$25 per visit, subject to deductible	Not Covered
Accidental Dental - Outpatient Surgical	$100 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Not Covered	$100 copay per visit for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly, subject to the deductible	Not Covered