



Version Updated: 09/11/2022

Rating Region: Syracuse

Healthy New York EPO		Healthy New York EPO	
Plan Overview			
Plan ID	78124NV1110009-00	78124NV1110009-00 (TTTTX)	
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 Active&Fit ExerciseRewards.		
Plan Type	Hybrid	Hybrid	
HSA Eligible	No	No	
Quote Effective	01/01/2022 - 03/31/2022	01/01/2023 - 03/31/2023	
Rate (\$)	Small Group	Small Group	
Single	\$460.26	\$501.33	
Subscriber & Spouse	\$920.53	\$1,002.65	
Subscriber & Child(ren)	\$782.45	\$852.26	
Family	\$1,311.75	\$1,428.77	
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 BlueCard Network	Coverage provided worldwide through our BlueCard® Network	
Student/Dependant coverage	Qualified dependents are covered to age 26	Qualified dependents are covered to age 26	
Domestic partner	Covered	Covered	
Wellness Incentives	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.	Active&Fit ExerciseRewards: New in 2023 - Fitness center visits are worth 2 points! Earn 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 Enterprise.	
Calm Stress Management Program	Not Applicable	New in 2023, a premium subscription to the Calm App is now an embedded benefit to help members experience better sleep, lower stress, and reduce anxiety.	
Plan cost-sharing highlights			
Plan cost-sharing highlights	In-Network	In-Network	Out-of-Network
Primary Care Office Visit	\$25 copay per visit, subject to deductible	\$25 copay per visit, subject to deductible	Not Covered

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Specialist Office Visit	\$40 copay per visit, subject to deductible	Not Covered	\$40 copay per visit, subject to deductible
Coinsurance	Covered at 100%	Not Covered	Covered at 100%
Deductible	In-Network: \$600 Individual / \$1,200 Family	Not Covered	In-Network: \$600 Individual / \$1,200 Family
Out of pocket maximum	\$4,000 Individual / \$8,000 Family	Not Covered	\$4,750 Individual / \$9,500 Family
Lifetime maximum	None	None	None
Plan Benefits			
Preventive Healthcare Services		Out-of-Network	In-Network
Well child visits	Covered In Full	Not Covered	Covered In Full
Adult routine physical exams	Covered In Full	Not Covered	Covered In Full
+Adult immunizations	Covered In Full	Not Covered	Covered In Full
+Mammography	Covered In Full	Not Covered	Covered In Full
+Pap smear	Covered In Full	Not Covered	Covered In Full
Routine GYN Exam	Covered In Full	Not Covered	Covered In Full
+Prostate cancer screening	Covered In Full	Not Covered	Covered In Full
+Colonoscopy	Preventive screenings covered in full	Not Covered	Preventive screenings covered in full
+Family Planning Services	Covered In Full	Not Covered	Covered In Full
Physician Office Services	In-Network	Out-of-Network	In-Network
Diagnostic Visits - In-Person or Virtual	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible	Not Covered	\$25 PCP copay; \$40 Specialist copay per visit, subject to deductible
Telemedicine with MD/Live	Covered In Full, subject to deductible	Covered at 100%, subject to the deductible	Covered In Full, subject to 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
Advanced Imaging Services	\$40 copay per visit, subject to the deductible	Not Covered	\$40 copay per visit, subject to the deductible
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
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
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
Chemotherapy	\$25 PCP copay per visit, subject to deductible	Not Covered	\$25 PCP copay per visit, subject to deductible
Radiation therapy	\$25 PCP copay per visit, subject to deductible	Not Covered	\$25 PCP copay per visit, subject to deductible
Maternity Services	In-Network	Out-of-Network	In-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)
Hospital care for mom (including delivery)	Subject to \$1,000 copay per admission, subject to the deductible	Not Covered	Subject to \$1,000 copay per admission, subject to the deductible
Newborn nursery care	Covered In Full, subject to deductible	Not Covered	Covered In Full, subject to deductible

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Prescription Drug Coverage	In-Network	Out-of-Network	In-Network
Prescription Drug Coverage	\$10/\$35/\$70	Not Covered	\$10/\$35/\$70
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
Inpatient Hospital Benefits	In-Network	Out-of-Network	In-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
Physician visits in the hospital	Covered In Full	Not Covered	Covered In Full
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
Surgery	\$100 copay per visit, subject to deductible	Not Covered	\$100 copay per visit, subject to deductible
Anesthesia	Covered In Full	Not Covered	Covered In Full
Emergency Care	In-Network	Out-of-Network	In-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
Freestanding urgent care center	\$60 copay per visit, subject to deductible	Not Covered	\$60 copay per visit, subject to deductible
Ambulance	\$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
Diagnostic x-rays	\$40 copay per visit, subject to the deductible	Not Covered	\$40 copay per visit, subject to the deductible
Advanced Imaging Services	\$40 copay per visit, subject to the deductible	Not Covered	\$40 copay per visit, subject to the deductible
Diagnostic laboratory and pathology	\$40 copay per visit, subject to the deductible	Not Covered	\$40 copay per visit, subject to the deductible
Surgical Care Facility Fee	\$100 copay per visit, subject to deductible	Not Covered	\$100 copay per visit, subject to deductible
Chemotherapy	\$25 copay per visit, subject to the deductible	Not Covered	\$25 copay per visit, subject to the deductible
Radiation Therapy	\$25 copay per visit, subject to the deductible	Not Covered	\$25 copay per visit, subject to the deductible
Mental Health and Substance Use	In-Network	Out-of-Network	In-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
Outpatient mental health care	\$25 copay per visit, subject to the deductible	Not Covered	\$25 copay per visit, subject to the deductible
Inpatient substance use 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
Outpatient substance use care	\$25 copay per visit, subject to the deductible	Not Covered	\$25 copay per visit, subject to the deductible
Other Services	In-Network	Out-of-Network	In-Network
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

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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
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
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
Durable medical equipment	Covered at 80%, subject to the deductible	Not Covered	Covered at 80%, subject to the deductible
External prosthetics	Covered at 80%, subject to the deductible	Not Covered	Covered at 80%, subject to the deductible
Chiropractic	\$40 Specialist copay per visit, subject to deductible	Not Covered	\$40 Specialist copay per visit, subject to deductible
Acupuncture	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
Vision Benefits	In-Network	Out-of-Network	In-Network
Adult Routine Vision Exam	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
Adult Eyewear	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
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
Dental Benefits	In-Network	Out-of-Network	In-Network
Adult Dental Care	Not Covered	Not Covered	Not Covered
Pediatric Dental: Preventative & Routine	\$25 per visit, subject to deductible	Not Covered	\$25 per visit, subject to deductible
Pediatric Major Dental Care & Medical Ortho	\$25 per visit, subject to deductible	Not Covered	\$25 per visit, subject to deductible
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

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefit. *Preventive Services coverage required by the Federal Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A," "B," "C" that are covered pursuant to the Federal Patient Protection and Affordable Care Act requirements.

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