

Affinity Health Plan: Essential Plan 1 AI/AN

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

Coverage Period: 01/01/2016-12/31/2016

Coverage for: Individual | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the schedule of benefits at www.affinityplan.org/EP-subscriber-contracts.aspx or by calling 1-866-247-5678.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	The Affinity Essential Plan does not have any deductible.
Is there an out-of-pocket limit on my expenses?	N/A	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. Essential Plans for American Indian and Alaskan Natives are not subject to any out-of-pocket costs.
What is not included in the out-of-pocket limit?	Premium payments and health care services that this plan doesn't 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.	Refer to the Schedule of Benefits in the Subscriber Contract for individual service limits.
Does this plan use a network of providers?	Yes. For a list of preferred providers , see http://providerlookup.affinityplan.org or call 1-866-247-5678.	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 . This plan only covers emergency out-of-network services.
Do I need a referral to see a specialist?	No.	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 6. See your schedule of benefits for additional information about excluded services .

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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 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	Cost If You Use An Out Of Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$0 copayment	Not covered	None
	Specialist visit	\$0 copayment	Not covered	None
	Other practitioner office visit	\$0 copayment	Not covered	None
	Preventive care/screening/immunization	Covered in full	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	\$0 copayment	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$0 copayment	Not covered	None

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If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.affinityplan.org	Generic drugs	\$0 Copayment (retail) \$0 Copayment (mail order)	Not covered	Retail prescriptions cover up to a 30 day supply; Mail Order covers a 31-90 day supply
	Preferred brand drugs	\$0 Copayment (retail) \$0 copayment (mail order)	Not covered	
	Non-preferred brand drugs	\$0 Copayment (retail) \$0 Copayment (mail order)	Not covered	See full Schedule of Benefits for specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0 copayment	Not covered	Preauthorization required. Any surgery involving a transplant must be performed at designated facilities.
	Office Surgery	\$0 copayment	Not covered	
	Physician/surgeon fees	\$0 copayment	Not covered	Preauthorization required.
If you need immediate medical attention	Emergency room services	\$0 copayment	\$0 copayment	None
	Emergency medical transportation	\$0 copayment	\$0 copayment	None
	Urgent care	\$0 copayment	\$0 copayment	None

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If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 copayment	Not covered	Preauthorization required. Any surgery involving a transplant must be performed at designated facilities.
	Physician/surgeon fee	\$0 copayment	Not covered	Preauthorization required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$0 copayment	Not covered	Pre authorization required.
	Mental/Behavioral health inpatient services	\$0 copayment	Not covered	Preauthorization required. However, preauthorization is not required for emergency admissions.
	Substance use disorder outpatient services	\$0 copayment	Not covered	Preauthorization required.
	Substance use disorder inpatient services	\$0 copayment	Not covered	Preauthorization required. However, preauthorization is not required for emergency admissions.
If you are pregnant	Prenatal and postnatal care	\$0 copayment	Not covered	Preauthorization required
	Delivery and all inpatient services	\$0 copayment	Not covered	Preauthorization required. Coverage is limited to 1 home care visit is covered at no cost-sharing if mother is discharged from hospital early.

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If you need help recovering or have other special health needs	Home health care	\$0 copayment	Not covered	Preauthorization required. Coverage is limited to 40 visits per plan year.
	Rehabilitation services (Outpatient)	\$0 copayment	Not covered	Coverage is limited to 60 visits per condition, per lifetime combined therapies. Speech and physical therapy are only covered following a hospital stay or surgery. Preauthorization required.
	Habilitation services	\$0 copayment	Not covered	Preauthorization required. Coverage is limited to 60 visits per condition, per lifetime combined therapies.
	Skilled nursing care	\$0 copayment	Not covered	Preauthorization required. Coverage is limited to 200 days per plan year.
	Durable medical equipment	\$0 copayment	Not covered	Preauthorization required.
	Hospice service	\$0 copayment	Not covered	Coverage is limited to 210 visits per plan year; 5 visits for family bereavement counseling. Copayment per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility.

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

- | | | | |
|---------------------|---------------------|---------------|-------------------------|
| • Chiropractic care | • Bariatric surgery | • Hearing Aid | • Infertility Treatment |
|---------------------|---------------------|---------------|-------------------------|

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: Complaint, Grievance & Appeal Unit Quality Management Department, Affinity Health Plan, Metro Center Atrium 1176 Eastchester Road Bronx, NY 10461. Tel: 888-543-9069 Fax: 718-536-3358.

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 Para obtener asistencia en Español, llame al 866-247-5678

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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.

NOTE: The information in these examples is based on the deductible for an individual only.

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Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,390
- Patient pays \$150

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	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$150

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

- Amount owed to providers: \$5,400
- Plan pays \$5,320
- Patient pays \$80

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	\$0
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$80

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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