

deductible or copayments. Monthly premiums depend on household income and family size.

- **Essential Plan coverage:** Comprehensive health insurance with \$0 premiums for adults meeting income and other eligibility requirements.
- **Healthy NY coverage:** Program offering more affordable health insurance for small businesses.

Benefits to purchasing the above commercial health insurance coverage on the New York State of Health marketplace include:

- Advanced premium tax credits for individual or small group coverage
- Cost-sharing reductions for individual coverage
- Additional cost-sharing waivers for diabetes care and care during and after pregnancy for individual coverage

Flexible Spending Account (FSA) and Health Savings Account (HSA)

Depending on your employer and insurance plan, you may have the option to open an FSA or HSA. FSAs and HSAs allow you to contribute pre-tax income to pay for out-of-pocket health care costs, thereby reducing your taxable income.

www.dfs.ny.gov

Learn More

For additional information about health insurance in New York, visit dfs.ny.gov/health-insurance.

Need Help with Something Else?

The New York State Department of Financial Services is committed to helping New Yorkers understand their rights and protections.

For assistance, or to file a complaint, visit the DFS website at www.dfs.ny.gov or call the DFS hotline at (800) 342-3736.

**Visit the DFS website
for more information
at www.dfs.ny.gov**



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Insurance Discounts and Savings

WAYS TO SAVE ON HEALTH CARE



This guide is provided for informational purposes only and does not constitute legal advice.

Understanding your health insurance coverage before receiving care can help you avoid unexpected costs and ensure that treatment is covered.

There are three payments your insurer might have you pay for treatment: money towards your deductible, copay, and/or coinsurance.

- **Deductible:** The amount you must pay for a covered health care service before your insurance plan begins to pay benefits.
- **Copayment (Copay):** A fixed dollar amount you are required to pay for a covered health care service. This is typically paid at the time a service is received.
- **Coinsurance:** A cost-sharing requirement under which you pay a specified percentage of the cost of covered health care services after a deductible has been paid.

Check your policy to understand your coverage before receiving a non-emergency service or treatment from a provider.

Preventive Care

Certain policies* will not require you to pay a deductible, copayment, or coinsurance for most preventive care, including:

- Preventive screenings for conditions such as breast cancer, cervical cancer, colon cancer, lung cancer, prostate cancer, maternal depression, osteoporosis, and HIV
- Well-child visits

- Well-woman preventive visits and prenatal care
- Breastfeeding services and supplies
- Immunizations

**If your health insurance ID card says, “fully insured coverage,” then your policy should fall into this category.*

Savings on Medications

Certain policies* will not require you to pay, or will limit the amount of, a deductible, copayment, or coinsurance for some medications or devices, including:

- Insulin
- Asthma inhalers (beginning in 2027)
- EpiPens and epinephrine nasal sprays (\$100 limit on cost-sharing)
- Contraceptives
- Prenatal vitamins
- PrEP
- Smoking cessation drugs

**If your health insurance ID card says, “fully insured coverage,” then your policy should fall into this category.*

Wellness Incentives

Your health insurance policy may include financial rewards and incentives, like gift cards or cash, for participating in wellness activities or for obtaining preventive services. In addition, your policy may provide discounts on wellness activities, like gym memberships.

Out-of-Network Cost-Sharing

Using an out-of-network provider may result in much higher out-of-pocket costs. Before receiving care, verify with your health insurer – not your provider – whether the provider is in-network. You can confirm a provider is in-network by visiting your health insurer’s website and searching the provider directory. For the most accurate results, enter your plan ID number or specific plan name if possible. You can also contact your health insurer directly to receive a list of participating providers.

You have a right to obtain a referral to an out-of-network provider at the in-network cost-sharing rate, if:

- your insurer does not have an in-network provider with the appropriate training and experience to meet your health care needs; or
- in-network providers cannot meet required appointment time frames for mental health and/or substance use disorder services.

If your insurer’s provider directory mistakenly lists a provider as being in-network, you are only responsible for the in-network deductible, copayment, or coinsurance if you obtain services from the provider.

Options for Affordable Coverage

- **Child Health Plus coverage:** Free or low-cost health insurance for children up to age 19 with no annual