

 **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 at www.iatsenbf.org or by calling 1-800-456-3863.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the chart starting on page 2 for your costs for services that this Plan covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the 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?	No.	There is no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the <u>out of pocket limit</u> ?	This plan has no out of pocket limit .	This is not applicable because there is no out of pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	Yes, the amount available in your CAPP account.	This plan will pay for covered expenses only up to this limit during each coverage period, even if your need is greater. You are responsible for all expenses above this limit. The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits.
Does this plan use a <u>network of providers</u> ?	No.	The plan treats <u>providers</u> the same in determining payment for the same services.
Do I need a referral to see a <u>specialist</u> ?	No.	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 8. See your policy or plan document for additional information about <u>excluded services</u> .

Questions on benefits?: Call the Fund Office at 1-800-456-3863, e-mail us at psc@iatsenbf.org or visit www.iatsenbf.org, or call ASO/SIDS at 516-396-5525 in New York or 877-390-5845 outside of New York. If you aren't clear about any of the underlined terms used in this form, see the Glossary.



- **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	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider’s office or clinic	Primary care visits to treat an injury or illness	Not applicable	Not applicable	To be eligible for reimbursement under this HRA plan, the expense must be a “Qualifying Expense” as defined in the plan and under IRS rules and you must have enough funds available in your CAPP account to cover the expense. Annual physical exams are limited to one per calendar year.
	Specialist visit			
	Other practitioner office visit			
Preventive care/screening/immunization	Not applicable	Not applicable		
If you have a test	Diagnostic test (x-ray, blood work)	Not applicable	Not applicable	To be eligible for reimbursement under this HRA plan, the expense must be a “Qualifying Expense” as defined in the plan and under IRS rules and you must have enough funds available in your CAPP account to cover the expense.
	Imaging (CT/PET scans, MRIs)			

If you need drugs to treat your illness or condition	Generic drugs	Not applicable	Not applicable	To be eligible for reimbursement under this HRA plan, the expense must be a “Qualifying Expense” as defined in the plan and under IRS rules and you must have enough funds available in your CAPP account to cover the expense.
	Brand drugs with no generic equivalent	Not applicable	Not applicable	
If you need drugs to treat your illness or condition	Brand drugs with a generic equivalent	Not applicable	Not applicable	To be eligible for reimbursement under this HRA plan, the expense must be a “Qualifying Expense” as defined in the plan and under IRS rules and you must have enough funds available in your CAPP account to cover the expense.
	Specialty drugs	Not applicable	Not applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	Not applicable	To be eligible for reimbursement under this HRA plan, the expense must be a “Qualifying Expense” as defined in the plan and under IRS rules and you must have enough funds available in your CAPP account to cover the expense.
	Physician/surgeon fees	Not applicable	Not applicable	
If you need immediate medical attention	Emergency room services	Not applicable	Not applicable	To be eligible for reimbursement under this HRA plan, the expense must be a “Qualifying Expense” as defined in the plan and under IRS rules and you must have enough funds available in your CAPP account to cover the expense. An ambulance is reimbursable only to and from hospital, and an ambulette is reimbursable only to and from a medical facility.
	Emergency medical transportation	Not applicable	Not applicable	
	Urgent care	Not applicable	Not applicable	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	Not applicable	To be eligible for reimbursement under this HRA plan, the expense must be a

	Physician/surgeon fee			“Qualifying Expense” as defined in the plan and under IRS rules and you must have enough funds available in your CAPP account to cover the expense.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not applicable	Not applicable	To be eligible for reimbursement under this HRA plan, the expense must be a “Qualifying Expense” as defined in the plan and under IRS rules and you must have enough funds available in your CAPP account to cover the expense.
	Mental/Behavioral health inpatient services	Not applicable	Not applicable	
	Substance use disorder outpatient services	Not applicable	Not applicable	
	Substance use disorder inpatient services	Not applicable	Not applicable	
If you are pregnant	Prenatal and postnatal care	Not applicable	Not applicable	To be eligible for reimbursement under this HRA plan, the expense must be a “Qualifying Expense” as defined in the plan and under IRS rules and you must have enough funds available in your CAPP account to cover the expense.
	Delivery and all inpatient services			

If you need help recovering or have other special health needs	Home health care	Not applicable	Not applicable	To be eligible for reimbursement under this HRA plan, the expense must be a “Qualifying Expense” as defined in the plan and under IRS rules and you must have enough funds available in your CAPP account to cover the expense. Reimbursement for a rental fee for durable medical equipment may not exceed the purchase price.
	Rehabilitation services	Not applicable	Not applicable	
	Habilitation services	Not applicable	Not applicable	
	Skilled nursing care	Not applicable	Not applicable	
	Durable medical equipment	Not applicable	Not applicable	
	Hospice service	Not applicable	Not applicable	
If your child needs dental or eye care	Eye exam	Not applicable	Not applicable	To be eligible for reimbursement under this HRA plan, the expense must be a “Qualifying Expense” as defined in the plan and under IRS rules and you must have enough funds available in your CAPP account to cover the expense.
	Glasses	Not applicable	Not applicable	
	Dental check-up	Not applicable	Not applicable	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn’t a complete list. Check your plan document for other <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Individual health insurance premiums 	<ul style="list-style-type: none"> • Private duty nursing • Routine foot care 	<ul style="list-style-type: none"> • Weight loss program

Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Chiropractic care | <ul style="list-style-type: none"> • Infertility treatment • Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. |
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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-456-3863. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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: Empire Blue Cross and Blue Shield P.O. Box 1407 Church Street Station New York, NY 10008-1407.

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 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 not meet the minimum value standard for the benefits it provides, but a participant must be enrolled in a group health plan that does provide minimum value to participate in this Plan C – Medical Reimbursement Program (MRP).**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-553-9603.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-553-9603.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-553-9603.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-553-9603.]

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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 \$6,380
- Patient pays \$1,160

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	\$10
Coinsurance	\$1,000
Limits or exclusions	\$150
Total	\$1,160

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

- Amount owed to providers: \$5,400
- Plan pays \$4,590
- Patient pays \$810

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	\$450
Coinsurance	\$280
Limits or exclusions	\$80
Total	\$810

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: 1-800-553-9603

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.