
 **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](http://www.iatsenbf.org) or by calling 1-800-456-3863.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$0</b> for In-Network providers. <b>\$750</b> Individual/ <b>\$1,875</b> Family for Out-of-Network providers.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
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?	Yes. <b>\$1,750</b> Individual/ <b>\$4,375</b> Family for In-Network providers; <b>\$7,500</b> Individual/ <b>\$18,750</b> Family for Out-of-Network providers.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out of pocket limit</u> ?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billed charges, and health care 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	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.empireblue.com">www.empireblue.com</a> or call 1-800-553-9603 for a list of In-Network providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.

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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 <b>excluded services</b> .
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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	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$25 Copayment/Visit for exams, evaluations and consultations, all other services require 20% coinsurance	Deductible and 40% Coinsurance	Hospital based clinic visits are not covered. If you go to an out-of-network physician for an annual wellness exam, benefits are limited to \$300.
	Specialist visit	\$50 Copayment		
	Other practitioner office visit	\$50 Copayment		
	Preventive care/screening/immunization	No Charges	Deductible and 40% Coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	Deductible and 40% Coinsurance	Failure to obtain preauthorization for Out-of-Network providers may result in no coverage or reduced coverage. Failure to obtain preauthorization for x-rays and other imaging may result in no coverage or reduced benefits.
	Imaging (CT/PET scans, MRIs)			

<p><b>If you need drugs to treat your illness or condition.</b></p>	Generic Drugs	\$5.00 retail \$10.00 mail order	\$5.00 retail; Claim must be submitted for retail; Not covered for mail order	<p>Certain drugs are subject to prior authorization, coverage limits, clinical programs, safety monitoring and quantity limits. Medications that can be obtained without a prescription are not covered. Certain drugs not in the formulary are excluded.</p>
	Brand drugs with no generic equivalent	20% of cost, \$40 minimum and \$60 maximum at retail; \$90 minimum and \$140 maximum for mail order	20% of cost, \$40 minimum and \$60 maximum; Claim must be submitted for retail; Not covered for mail order	
	Brand drugs with a generic equivalent	40% of cost, \$50 minimum and \$70 maximum at retail; \$115 minimum and \$175 maximum for mail order	40% of cost, \$50 minimum and \$70 maximum; Claim must be submitted for retail; Not covered for mail order	
	Specialty drugs	20% of cost, \$40 minimum and \$150 maximum at retail; \$90 minimum and \$300 maximum for mail order	20% of cost, \$40 minimum and \$150 maximum; Claim must be submitted for retail; Not covered for mail order	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	<b>20%</b> Coinsurance	Deductible and <b>40%</b> Coinsurance	<p>Failure to obtain preauthorization may result in no coverage or reduced benefits.</p>
	Physician/surgeon fees	<b>20%</b> Coinsurance	Deductible and <b>40%</b> Coinsurance	

<b>If you need immediate medical attention</b>	Emergency room services	<b>\$100</b> Copayment/Visit	<b>\$100</b> Copayment/Visit	If admitted within 24 hours, the ER copayment is waived.
	Emergency medical transportation	<b>20%</b> Coinsurance	\$0 as long as the ambulance charge does not exceed the maximum allowed amount. You pay any difference between maximum allowed amount and actual charge.	Out-of-network providers are covered as in-network, subject to meeting "emergency" criteria. If services are delivered by an out-of-network land ambulance provider not licensed under the NY Public Health Law, you may be required to pay up to the difference between the reasonable and customary allowed amount and the provider's total charges.
	Urgent care	<b>20%</b> Coinsurance	Deductible and <b>40%</b> Coinsurance	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	<b>20%</b> Coinsurance	Deductible and <b>40%</b> Coinsurance	Failure to obtain preauthorization may result in no coverage or reduced benefits.
	Physician/surgeon fee			
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	<b>\$25</b> Copay/Visit for exams, evaluations and consultations, all other services require <b>20%</b> coinsurance	Deductible and <b>40%</b> Coinsurance	Failure to obtain preauthorization may result in no coverage or reduced benefits.
	Mental/Behavioral health inpatient services	<b>20%</b> Coinsurance	Deductible and <b>40%</b> Coinsurance	Failure to obtain preauthorization may result in no coverage or reduced benefits.
	Substance use disorder outpatient services	<b>\$25</b> Copayment/Visit for exams, evaluations and consultations, all other services require <b>20%</b> coinsurance	Deductible and <b>40%</b> Coinsurance	Failure to obtain preauthorization may result in no coverage or reduced benefits.
	Substance use disorder inpatient services	<b>20%</b> Coinsurance	Deductible and <b>40%</b> Coinsurance	Failure to obtain preauthorization may result in no coverage or reduced benefits.

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<b>If you are pregnant</b>	Prenatal and postnatal care	<b>\$25</b> for initial exam and evaluation, other services subject to <b>20%</b> coinsurance	Deductible and <b>40%</b> Coinsurance	Failure to obtain preauthorization may result in no coverage or reduced benefits.
	Delivery and all inpatient services			
<b>If you need help recovering or have other special health needs</b>	Home health care	<b>20%</b> Coinsurance	<b>40%</b> Coinsurance	Coverage is limited to 200 visits per calendar year (a visit equals four hours of care).
	Rehabilitation services	<b>\$50</b> Copayment/Visit for examinations, evaluations and consultations; all other services require 20% coinsurance	Not Covered	Coverage is limited to 50 visits per calendar year for Occupational, Speech and Vision therapy combined, with a separate 50 visits per calendar year limit for outpatient Physical Therapy and Rehabilitation. Failure to obtain preauthorization may result in reduced or no coverage.
	Habilitation services			
	Skilled nursing care	<b>20%</b> Coinsurance	Not covered	Coverage is limited to 60 days per calendar year. Failure to obtain preauthorization for In Network providers may result in no coverage or reduced coverage.
	Durable medical equipment	<b>20%</b> Coinsurance	Not Covered	Failure to obtain pre-authorization may result in no coverage or reduced benefits.
	Hospice service	<b>20%</b> Coinsurance	Not Covered	Coverage is limited to 210 days per lifetime.
<b>If your child needs dental or eye care</b>	Eye exam	No charges for one exam each 12 months	Exams covered once every 12 months up to network allowance	Children are fully covered for exams once per year up through the age of 18
	Glasses	No charges for one pair every 24 months	Reimbursed up to \$100 each 24 months	
	Dental check-up	No charges for up to two per calendar year	Covered up to network allowance	Children are fully covered for two exams per year up through the age of 18.

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**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"> <li>• Cosmetic surgery</li> <li>• Long term care</li> </ul>	<ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss program</li> </ul>

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"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Most coverage provided outside the United States. See <a href="http://www.bcbs.com/bluecardworldwide">www.bcbs.com/bluecardworldwide</a></li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>

**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](http://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](http://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 meet the minimum value standard for the benefits it provides.**

**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.]

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

## 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$10
Coinsurance	\$1,000
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,160</b>

### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$450
Coinsurance	\$280
Limits or exclusions	\$80
<b>Total</b>	<b>\$810</b>

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.

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