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| **Exclamation** | **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 by calling Colleen Jimerson at 716-376-8204. | | |
| **Important Questions** | | **Answers** | **Why this Matters:** | |
| What is the overall **deductible**? | | For in-network providers  **$0** person / **$0** family  For out-of-network providers  **$250** person / **$500** family | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**. | |
| Are there other **deductibles** for specific services? | | No. | You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. | |
| Is there an **out-of pocket limit** on my expenses? | | No. For in-network providers.  Yes. For out-of-network providers  **$2,000** individual/ **$4,000** family | 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. This limit helps you plan for health care expenses. | |
| What is not included in **out-of-pocket** limit? | | 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 any limits on what the plan will pay for *specific* covered services, such as office visits. | |
| Does this plan use a **network** of **providers**? | | Yes. See [www.bcbswny.com](http://www.bcbswny.com) for a list of participating providers. | 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**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. | |
| Do I need a referral to see a **specialist?** | | No. | You can see the **specialist** 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 5. See your policy or plan document for additional information about **excluded services**. | |

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| **Exclamation** | * **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service. * **Co-insurance** 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 **co-insurance** 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 difference. (This is called **balance billing**.) * This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts. | | | | | |
| **Common Medical Event** | | **Services You May Need** | **Your cost if you use a** | | **Limitations & Exceptions** |
| In-Network Provider | Out-of-Network Provider |
| If you visit a health care **provider’s** office or clinic | | Primary care visit to treat an injury or illness | $10 co-pay/visit | 20% co-insurance after deductible |  |
| Specialist visit | $10 co-pay/visit | 20% co-insurance after deductible |  |
| Other practitioner office visit | $10 co-pay/visitfor chiropractor | 20% co-insurance after deductible for chiropractor |  |
| Preventive care /screening/ immunization | $0 co-pay | $0 for Flu Shot;  Other preventive services either 20% co-insurance after deductible or not covered | See your plan document for additional information. |
| If you have a test | | Diagnostic test (x-ray, blood work) | $10 co-pay/visit; no charge for blood work | 20% co-insurance after deductible |  |
| Imaging (CT/PET scans, MRIs) | $10 co-pay/visit | 20% co-insurance after deductible |  |

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| **Common Medical Event** | **Services You May Need** | **Your cost if you use a** | | **Limitations & Exceptions** |
| In-Network Provider | Out-of-Network Provider |
| **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available at [www.express-scripts.com](http://www.express-scripts.com). | Generic drugs | $4 | Not covered | Must be filled at a participating pharmacy. |
| Preferred brand drugs | $10 | Not covered | Must be filled at a participating pharmacy. |
| Non-preferred brand drugs | $10 | Not covered | Must be filled at a participating pharmacy. |
| Specialty drugs | Follows the formulary | Follows the formulary | Must be filled at a participating pharmacy. May require prior authorization |
| If you have outpatient surgery | Facility fee (e.g. ambulatory surgery center) | $10 co-pay/visit | 20% co-insurance after deductible |  |
| Physician/ surgeon fees | $0 | 20% co-insurance after deductible |  |
| If you need immediate medical attention | Emergency room services | $50 co-pay/visit | $50 co-pay/visit |  |
| Emergency medical transportation | $50 co-pay/visit | $50 co-pay/visit |  |
| Urgent Care | $10 co-pay/visit | 20% co-insurance after deductible |  |
| If you have a hospital stay | Facility fee (e.g. hospital room) | $0 | 20% co-insurance after deductible |  |
| Physician/ surgeon fees | $0 | 20% co-insurance after deductible |  |

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| **Common Medical Event** | **Services You May Need** | **Your cost if you use a** | | **Limitations & Exceptions** |
| In-Network Provider | Out-of-Network Provider |
| If you have mental health, behavioral health, or substance abuse needs | Mental/ Behavioral health outpatient services | $10 co-pay/visit | 20% co-insurance after deductible |  |
| Mental/ Behavioral health inpatient services | $0 | 20% co-insurance after deductible |  |
| Substance use disorder outpatient services | $10 co-pay/visit | 20% co-insurance after deductible |  |
| Substance use disorder inpatient | $0 | 20% co-insurance after deductible |  |
| If you are pregnant | Prenatal and postnatal care | $10 co-pay/visit | 20% co-insurance after deductible | For participating providers, cost share applies only to initial visit to determine pregnancy |
| Delivery and all inpatient services | $0 | 20% co-insurance after deductible |  |
| If you need help recovering or have other special health needs | Home health care | $10 co-pay/visit | 20% co-insurance after deductible |  |
| Rehabilitation services | $0 for acute inpatient physical rehabilitation;  $10 co-pay/outpatient visit | 20% co-insurance after deductible | Acute inpatient physical rehab maximum of 45 days per year combined in and out of network.  Outpatient services have a maximum of 20 visits per year combined for physical therapy, occupational therapy and speech therapy. |
| Habilitation services | $10 co-pay/visit | 20% co-insurance after deductible |  |
| Skilled Nursing care | $0 | 20% co-insurance after deductible |  |
| Durable medical equipment | 20% co-insurance | 50% co-insurance after deductible |  |
| Hospice service | $0 co-pay/visit | 20% co-insurance after deductible | 210 days combined with in and out of network |
| If your child needs dental or eye care | Eye exam | $0 co-pay/visit | Not covered | 1 per year for under age 14 |
| Glasses | Not covered | Not covered |  |
| Dental check-up | Not covered | Not covered |  |

**Excluded Services & Other Covered Services:**

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| **Services Your Plan Does NOT Cover** (This isn’t a complete list. Check your policy or plan document for other **excluded services**.) | | |
| * Acupuncture | * Cosmetic surgery | * Dental care (Adult) |
| * Hearing aids | * Long-term care | * Private-duty nursing |
| * Routine foot care | * Weight Loss programs |  |
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| **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.) | | |
| * Non-emergency care when traveling outside the United States | * Chiropractic Care | * Routine eye care (Adult) |
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**This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.**

**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 716-376-8204. 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: 1-888-393-3200.

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

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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.   |  |  | | --- | --- | | **Copy of CautionGray_Org.bmp** | **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 $7,350 * Patient pays $190  |  |  | | --- | --- | | **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 | | Co-pays | $20 | | Co-insurance | $0 | | Limits or exclusions | $170 | | **Total** | **$190** | | |  | | --- | | Managing type 2 diabetes  (routine maintenance of a well-controlled condition) |  * Amount owed to providers: $4,100 * Plan pays $2,120 * Patient pays $3280  |  |  | | --- | --- | | **Sample care costs:** |  | | Prescriptions | $1,500 | | Medical Equipment and Supplies | $1,300 | | Office Visits and Procedures | $730 | | Education | $290 | | Laboratory test | $140 | | Vaccines, other preventive | $140 | | **Total** | **$4,100** |  |  |  | | --- | --- | | **Patient Pays:** |  | | Deductibles | $0 | | Co-pays | $100 | | Co-insurance | $250 | | Limits or exclusions | $2,930 | | **Total** | **$3,280** | |

**Questions and answers about the Coverage Examples:**

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| **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**, **co-payments**, and **co-insurance** 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. |  | **Can I use Coverage Example to compare plans?**   |  |  | | --- | --- | | Yes_Org..bmp | **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. | |
| **Does the Coverage Example predict my own care need?**   |  |  | | --- | --- | | No_Org.bmp | **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. | |
| **Are there other costs I should consider when comparing plans?**   |  |  | | --- | --- | | Yes_Org..bmp | **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 **co-payments**, **deductibles**, and **co-insurance**. 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. | |
| **Does the Coverage Example predict my future expenses?**   |  |  | | --- | --- | | No_Org.bmp | **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. | |