# Empire BlueCross
# WSWHE Counties Health Insurance Consortium Trust: HRA

**Coverage Period: 07/01/2014 – 06/30/2015**

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

**Coverage for:** Medical | **Plan Type:** HRA

**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.empireblue.com or by calling 1-800-342-9816.

* **Health Reimbursement Accounts (HRA) Contribution**: **$1,000** Individual/**$2,000** Family

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For all providers: **$1,500** individual **/ $3,000** family. Doesn't apply to home health care, vision care, or in-network preventive care. | 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?** | For in-network providers: **$3,500** individual **/ $7,000** family. For out-of-network providers: **$7,500** individual **/ $15,000** 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 the 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. For a list of **in-network providers**, see www.empireblue.com or call 1-800-342-9816. | 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**. |

**Questions:** Call **1-800-342-9816** or visit us at **www.empireblue.com**

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.empireblue.com** or call **1-800-342-9816** to request a copy.

- **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 visit to treat an injury or illness | 10% coinsurance | 30% coinsurance | Hospital clinics are not covered. |
| | Specialist visit | 10% coinsurance | 30% coinsurance | Hospital clinics are not covered. |
| | Other practitioner office visit | 10% coinsurance | 30% coinsurance | For chiropractic care, Empire's network provider must obtained authorization for clinical/medical necessity for in-network services. Hospital clinics are not covered. |
| | Preventive care/screening/immunization | No Charge | 30% coinsurance | In-network, no charge is required for screenings for mammography, cervical cancer, colorectal cancer, prostate cancer, hypercholesterolemia, diabetes for pregnant women, testing for bone density, annual physicals and up to two annual OB/GYN exams. Hospital clinics are not covered. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance | 30% coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% coinsurance | This service must be pre-certified; you are responsible for penalties applied if precertification is not obtained. |

| 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 need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.empireblue.com | Tier 1 drugs | $10/retail prescription<br>$20/mail-order prescription | Not Covered | Retail prescriptions are limited to a 30-day supply; mail-order prescriptions are limited to a 90-day supply.<br><br>To receive a 90-day supply, your prescription must be written specifically for a 90-day supply.<br><br>Deductible must be met before 3-tier copay structure applies. |
| | Tier 2 drugs | $20/retail prescription<br>$40/mail-order prescription | | |
| | Tier 3 drugs (includes contraceptives) | $40/retail prescription<br>$80/mail-order prescription | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | Pre-certification is required for ambulatory surgery for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures, and also for cosmetic surgery, which must be medically necessary. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | |
| **If you need immediate medical attention** | Emergency room services | 10% coinsurance | 10% coinsurance | Waived if admitted within 24 hours. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | ——————none—————— |
| | Urgent care | 10% coinsurance | 10% coinsurance | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | This service must be pre-certified; you are responsible for penalties applied if precertification is not obtained. Inpatient physical therapy, physical medicine or rehabilitation has a 90-day limit per calendar year. |
| | Physician/surgeon fee | 10% coinsurance | 30% coinsurance | |

| 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 have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 10% coinsurance | 30% coinsurance | Inpatient services must be pre-certified by the Behavioral Healthcare Manager; you are responsible for penalties applied if precertification is not obtained. |
| | Mental/Behavioral health inpatient services | 10% coinsurance | 30% coinsurance | |
| | Substance use disorder outpatient services | 10% coinsurance | 30% coinsurance | |
| | Substance use disorder inpatient services | 10% coinsurance | 30% coinsurance | |
| **If you are pregnant** | Prenatal and postnatal care | 10% coinsurance | 30% coinsurance | ————————none———————— |
| | Delivery and all inpatient services | 10% coinsurance | 30% coinsurance | This service must be pre-certified; you are responsible for penalties applied if precertification is not obtained. |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 30% coinsurance | Benefit covers 200 visits per calendar year. Home infusion therapy has no visit limits and is not covered out-of-network. |
| | Rehabilitation services | 10% coinsurance | 30% coinsurance | Physical therapy has a 90-visit inpatient limit and a 90-visit limit outpatient/office per calendar year. Speech/language and occupational therapies have a combined 30-visit limit. This service must be pre-certified; you are responsible for penalties applied if precertification is not obtained. |
| | Habilitation services | 10% coinsurance | 30% coinsurance | All rehabilitation and habilitation visits count toward your rehabilitation visit limit. This service must be pre-certified; you are responsible for penalties applied if precertification is not obtained. |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | Benefit covers 120 days in facility per calendar year. |

| 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 |
|---|---|---|---|---|
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | This service must be pre-certified; you are responsible for penalties applied if precertification is not obtained. |
| | Hospice service | 10% coinsurance | 30% coinsurance | Benefit covers 210 days per lifetime. |
| **If your child needs dental or eye care** | Eye exam | $5/exam | 100% coinsurance, less $30 allowance | Benefit applies to one exam every 24 months. |
| | Glasses | No Charge for lenses<br>$10/frames<br>$10/soft lenses<br>$35 allowance for non-plan frames | 100% coinsurance, less $30 allowance for frames (contact the plan for lens allowance details) | For in-network services you must use a Davis Vision network provider. |
| | Dental check-up | Not Covered | Not Covered | ——————none—————— |

## 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.)**

- Dental care
- Hearing aids
- Weight loss programs
- Invitro Fertilization
- Long-term care
- Cosmetic surgery
- Private-duty nursing
- Routine foot care

**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 (medically necessary)
- Routine eye care
- Coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Acupuncture
- $400 gym reimbursement

## 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 1-800-342-9816. 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 BlueCross
Attn.: Appeals/Grievances
P.O. Box 1407
Church Street Station
New York, NY 10008

For ERISA information, please contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact:

Community Service Society of New York, Community Health Advocates
105 East 22nd Street, 8th floor
New York, NY 10010
(888) 614-5400
http://www.communityhealthadvocates.org/

## 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:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

*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:** $7,390
- **Plan pays** $5,290
- **Patient pays** $2,100

**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 | $1,500 |
| Copays | $20 |
| Coinsurance | $580 |
| Limits or exclusions | $0 |
| **Total** | **$2,100** |

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

- **Amount owed to providers:** $5,320
- **Plan pays** $3,340
- **Patient pays** $1,980

**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 | $1,500 |
| Copays | $330 |
| Coinsurance | $150 |
| Limits or exclusions | $0 |
| **Total** | **$1,980** |

# 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.