

# City of New York: Empire BlueCross BlueShield

## Hospital Only PPO

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

Coverage Period: 07/01/2016-12/31/2016

Coverage for: Individual/Family Plan Type: PPO



**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/nyc](http://www.empireblue.com/nyc) or by calling 1-800- 433-9592.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	N/A	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. For in-network providers <b>\$1,250</b> person / <b>\$2,500</b> family For out-of-network providers <b>N/A</b>	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> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.empireblue.com/nyc">www.empireblue.com/nyc</a> or call 1-800-433-9592 or 1-800-521-9574 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 specialist	Not Covered	NONE
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 <u>excluded services</u> .

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OMB Control Numbers 1545-2229,  
1210-0147, and 0938-1146

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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.

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<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	Not covered	Not covered	_____none_____
	Specialist visit	Not covered	Not covered	_____none_____
	Other practitioner office visit	Not covered	Not covered	_____none_____
	Preventive care/screening/immunization	Not covered	Not covered	_____none_____
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	Not covered	Not covered	_____none_____
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	_____none_____
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.empireblue.com/nyc">www.empireblue.com/nyc</a>	Generic drugs	Not covered by Empire BlueCross BlueShield	Not covered	_____none_____
	Preferred brand drugs	Not covered by Empire BlueCross BlueShield	Not covered	_____none_____
	Non-preferred brand drugs	Not covered by Empire BlueCross BlueShield	Not covered	_____none_____
	Specialty drugs	Not covered by Empire BlueCross BlueShield	Not covered	_____none_____

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance up to \$200 annual max.	\$500 copay and 20% coinsurance	You must call NYC Healthline for authorization and approval for the following procedures: possible/cosmetic procedures, reconstruction, outpatient transplants, optical/vision related procedures, breast reconstruction, cochlear implants, functional endoscopy/nasal surgery, spinal stimulator implants, joint replacements and obesity surgeries, dialysis, Experimental/investigational procedures, hyperbaric O2 chamber, infertility with underlying condition, pain management, spinal Stimulatory Implants, Wound vac, Bariatric surgery, Spinal Surgery.
	Physician/surgeon fees	Not covered	Not covered	—————none—————
If you need immediate medical attention	Emergency room services	\$150 copay	\$150 copay	Copay waived if admitted.
	Emergency medical transportation	Not Covered	Not Covered	Air ambulance only covered when medically necessary
	Urgent care	Not Covered	Not Covered	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 copay and 0% coinsurance	\$500 copay and 20% coinsurance	You must call NYC Healthline for approval. If there is no call, claim is subject to a penalty of \$250 per day up to a maximum of \$500 and is subject to retrospective review by NYCHSRO. There has to be a gap of 90 days between admissions before the 365 days will renew.

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	Physician/surgeon fee	Not Covered	Not Covered	_____none_____
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Not Covered	Not Covered	_____none_____
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	_____none_____
	Substance use disorder outpatient services	Not Covered	Not Covered	_____none_____
	Substance use disorder inpatient services	Not Covered	Not Covered	_____none_____
<b>If you are pregnant</b>	Prenatal and postnatal care	Not Covered	Not Covered	_____none_____
	Delivery and all inpatient services	\$300 copay and 0% coinsurance	\$500 copay and 20% coinsurance	You must call NYC Healthline if a vaginal delivery is more than a 48 hour admission or a C-section delivery is more than a 96 hour admission. If there is no call, claim is subject to a penalty of \$250 per day up to a maximum of \$500 and is subject to retrospective review by NYCHSRO. There has to be a gap of 90 days between admissions before the 365 days will renew. Doctor's charges are not covered.

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<b>If you need help recovering or have other special health needs</b>	Home health care	Not Covered	Not Covered	—————none—————
	Rehabilitation services	Not Covered	Not Covered	See Skilled nursing care for Limitatiions & Exceptions.
	Habilitation services	Not Covered	Not Covered	See Skilled nursing care for Limitatiions & Exceptions.
	Skilled nursing care	\$300 copay and 0% coinsurance	\$500 copay and 20% coinsurance	Coverage is limited to 90 days annual max. NYC Healthline may substitute benefits if medically appropriate. 2 1/2 outpatient visits=1 day in a skilled nursing facility. 1 day in an acute rehabilitation facility = 2 days in a skilled nursing facility. Of the 90 days there are 30 occupational and speech therapy visits combined allowed.
	Durable medical equipment	Not Covered	Not Covered	—————none—————
	Hospice service	No Charge	No Charge	Coverage is limited to 210 days lifetime max.
<b>If your child needs dental or eye care</b>	Eye exam	Not covered	Not covered	—————none—————
	Glasses	Not covered	Not covered	—————none—————
	Dental check-up	Not covered	Not covered	—————none—————

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### 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.)

- |                             |  |  |
|-----------------------------|--|--|
| • Acupuncture               | • Home health care   | • Non-emergency care when traveling outside the U.S. |
| • Chiropractic care         | • Infertility treatment  | • Office visits                                      |
| • Cosmetic surgery          | • Long-term care   | • Private-duty nursing                               |
| • Durable medical equipment | • Mental Health and Substance Abuse inpatient and outpatient services  | • Routine eye care                                   |
| • Diagnostic tests          | • Most coverage provided outside the United States. See <a href="http://www.BCBS.com/bluecardworldwide">www.BCBS.com/bluecardworldwide</a> | • Routine foot care                                  |
| • Dental care               |  | • Weight loss programs                               |
| • Hearing aids              |  |  |

#### 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.)

- |                     |                          |
|---------------------|--------------------------|
| • Bariatric Surgery | • Cardiac Rehabilitation |
|---------------------|--------------------------|

### 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 1-800-433-9592. 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).

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### 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 BlueShield

P.O.Box1407

Church Street Station

New York, NY 10008

Phone: 1-800-767-8672

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

NYC Healthline

Appeal Coordinator

Maildrop R4-J Box 11825

11 Corporate Woods Blvd

Albany, NY 12211

### 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 not 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.**

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-433-9592

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-433-9592

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-433-9592

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-800-433-9592

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

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## Coverage Examples

Coverage Period: 07/01/2016-12/31/2016

Coverage for: Individual/Family | Plan Type: PPO

## 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 \$4,200

■ Patient pays \$ 3,340

#### 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	\$300
Coinsurance	\$0
Limits or exclusions	\$3,040
<b>Total</b>	<b>\$3,340</b>

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

**Amount owed to providers: \$5,400**

■ Plan pays \$0

■ Patient pays \$ 5,400

#### 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	\$0
Coinsurance	\$0
Limits or exclusions	\$5,400
<b>Total</b>	<b>\$5,400</b>

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## 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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