NYCDC of Carpenters Welfare Fund: Early Retirees

Coverage Period:01/01/2016 – 12/31/2016

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

Coverage for: Individual/Family | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Summary Plan Description ("SPD") either at www.nyccbf.com or by calling the Fund Office at 1-212-366-7300 or 1-800-529-3863.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$500** Individual / **$1,250** Family Out-of-Network: **$750** Individual / **$1,875** Family Doesn't apply to copays, preventive care, emergency room services, prescription drugs, dental benefits, hearing aids and vision benefits.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your SPD 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?	Yes. **$250** Individual for Prescription Drugs and **$50** Individual / **$150** Family for Comprehensive Dental Program. ("CDP") (CDP only applies to those who live outside the Aetna DMO area.) There are no other specific **deductibles.**	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	In-Network: **$2,000** Individual / **$5,000** Family Prescription Drugs: **$3,250** Individual / **$8,125** Family Out-of-Network: **$3,750** Individual / **$9,375** 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 **1-800-553-9603**.	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 6. See your SPD for additional information about **excluded services**.

- **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	$20 copay/visit	40% coinsurance after deductible	————————none————
	Specialist visit	$25 copay/visit	40% coinsurance after deductible	————————none————
	Other practitioner office visit	Acupuncture: $25 copay/visit Chiropractic care: $20 copay/visit	Acupuncture: 40% coinsurance after deductible Chiropractic care: Not covered	Chiropractic care limited to 45 visits per calendar year. Failure to pre-certify chiropractic care after 5th visit may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
	Preventive care/ screening/ immunization	No Charge	40% coinsurance after deductible	Subject to age and frequency limitations.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	40% coinsurance after deductible	When outside of Empire's service area, you must use a lab contracted with local Blue plan.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	40% coinsurance after deductible	Failure to pre-certify high tech radiology services may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.

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 More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail (30-day supply): $15 copay/Rx Mail Order (90-day supply): $25 copay/Rx	Not Covered	Contraceptives and certain ACA preventive medications, including over-the-counter drugs, are available at no cost with a prescription. Mandatory generic feature: Brand name drugs are only covered if no generic equivalent is available. If a brand name drug is selected, you must pay the applicable copay plus the difference in cost between the brand-name drug and the generic drug. Mandatory mail order program: Maintenance drugs for chronic conditions must be obtained by mail order. Specialty drugs: Must use Accredo specialty pharmacy (Mail Order only). Preauthorization required. To reach the specialty pharmacy, call 1-800-803-2523.
	Preferred Brand name drugs	Retail (30-day supply): $25 copay/Rx Mail Order (90-day supply): $45 copay/Rx	Not Covered	
	Non-Preferred Brand name drugs	Retail (30-day supply): $40 copay/Rx Mail Order (90-day supply): $75 copay/Rx	Not Covered	
	Specialty drugs	Mail Order only: Applicable copay above	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	40% coinsurance after deductible	Failure to pre-certify services may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
	Physician/surgeon fees	10% coinsurance after deductible	40% coinsurance after deductible	
If you need immediate medical attention	Emergency room services	$200 copay/visit	$200 copay/visit	Copay waived if admitted within 24 hours.
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance of network rate after deductible	Transportation by air or land ambulance to nearest acute care hospital for emergency treatment.
	Urgent care	$25 copay/visit	40% coinsurance after deductible	——————none——————

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 a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	40% coinsurance after deductible	Failure to pre-certify admissions may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary. This benefit reduction also applies to certain Same-Day Surgery and professional services rendered during an inpatient admission.
	Physician/surgeon fee	10% coinsurance after deductible	40% coinsurance after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office visit: $20 copay/ visit Other outpatient services: 10% coinsurance after deductible	40% coinsurance after deductible	Failure to pre-certify partial hospital intensive outpatient programs may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
	Mental/Behavioral health inpatient services	10% coinsurance after deductible	40% coinsurance after deductible	Failure to pre-certify admissions may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
	Substance use disorder outpatient services	Office visit: $20 copay/visit Other outpatient services: 10% coinsurance after deductible	40% coinsurance after deductible	Failure to pre-certify partial hospital intensive outpatient programs may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
	Substance use disorder inpatient services	10% coinsurance after deductible	40% coinsurance after deductible	Failure to pre-certify admissions may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
If you are pregnant	Prenatal and postnatal care	10% coinsurance after deductible	40% coinsurance after deductible	————————none————————
	Delivery and all inpatient services	10% coinsurance after deductible	40% coinsurance after deductible	Out-of-network birthing centers not covered.

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 help recovering or have other special health needs	Home health care	10% coinsurance after deductible	Not Covered	Limited to 200 visits per calendar year (1 visit equals 4 hours of care). Treatment maximums are combined for in-network and out-of-network care.
	Rehabilitation services	Inpatient: 10% coinsurance after deductible Outpatient office setting: $20 copay/visit Outpatient hospital setting: $25 copay/visit	Not Covered	Physical therapy limited to 45 outpatient visits and 30 inpatient days per calendar year. Occupational and speech therapy limited to 45 outpatient visits per calendar year. Inpatient occupational and speech therapy not covered.
	Habilitation services	Inpatient: 10% coinsurance after deductible Outpatient office setting: $20 copay/visit Outpatient hospital setting: $25 copay/visit	Not Covered	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	10% coinsurance after deductible	Not Covered	Limited to 60 days per calendar year. Failure to pre-certify services may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
	Durable medical equipment	10% coinsurance after deductible	Not Covered	Failure to pre-certify services may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
	Hospice service	10% coinsurance after deductible	Not Covered	Limited to 210 days per lifetime. Failure to pre-certify services may result in a benefit reduction up to 50% to a maximum of $2,500 or denial of claim if not medically necessary.
If your child needs dental or eye care	Eye exam	No Charge	Amount over $25 Plan allowance	Vision benefits separately administered by Comprehensive Professional Systems or General Vision Services. Eye exam and glasses or contact lenses limited to once every 12 months. Selection of special lenses and coatings may require you to pay a portion of the cost, even in-network.
	Glasses	No Charge	Amount over $100 Plan allowance	
	Dental check-up	Aetna DMO: No Charge Aetna CDP: Amount over Plan allowance	Aetna DMO: Not Covered Aetna CDP: Amount over Plan allowance	Dental benefits separately administered by Aetna. If you are enrolled in the CDP, services subject to a deductible of $50 individual / $150 family. Frequency limits apply.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your SPD for other excluded services.)

- Birthing centers (out-of-network)
- Cosmetic surgery
- Long-term care
- Inpatient occupational and speech therapy
- Private-duty nursing
- Routine foot care
- Weight loss programs (except as required by the ACA)

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

- Dental care (Adult)
- Bariatric surgery
- Routine eye care (Adult)
- Hearing aids (limited to $350/ear, 1 every 4 years)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.BCBS.com/bluecardworldwide

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 1-800-529-3863. 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 Appeal and Grievance Dept., P.O. Box 1407, Church Street Station, New York, NY 10008-1407, or Express Scripts, 811 Royal Ridge Parkway, Irving, TX 75063, Attn: Administrative Reviews; or Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform; or New York State Department of Insurance, 1-(800) 342-3736. 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 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 1-212-366-7300 o 1-800-529-3863.

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** $6,270
- **Patient pays** $1,270

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	$500
Copays	$80
Coinsurance	$660
Limits or exclusions	$30
Total	**$1,270**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,910
- **Patient pays** $1,490

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	$500
Copays	$820
Coinsurance	$90
Limits or exclusions	$80
Total	**$1,490**

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.