

# Empire Blue Cross

## Empire Preferred Guided Access - cecb

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

Coverage Period: 01/01/2014 – 12/31/2014

Coverage for: Individual + Family | Plan Type: HMO



**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](http://www.empireblue.com) or by calling (855) 330-1104.

| Important Questions                                       | Answers   | Why this Matters:   |
|---|---|---|
| What is the overall <u>deductible</u> ?                   | <b>\$1,000</b> person / <b>\$2,000</b> family for In-Network Provider.<br>Does not apply to Copayments, and Preventive Care.      | You must pay all 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 3 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 deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.   |
| Is there an <u>out-of-pocket limit</u> on my expenses?    | Yes; <b>\$6,250</b> person / <b>\$12,500</b> family for In-Network Provider.  | 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; This policy has no overall annual limit on the amount it will pay each year.  | The chart starting on page 3 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</u> of <u>providers</u> ? | Yes; See <a href="http://www.empireblue.com">www.empireblue.com</a> or call (855) 330-1104 for a list of participating 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 3 for how this plan pays different kinds of <u>providers</u> . |

Questions: Call (855) 330-1104 or visit us at [www.empireblue.com](http://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.cciio.cms.gov](http://www.cciio.cms.gov) or call (855) 330-1104 to request a copy.

| Important Questions                                     | Answers   | Why this Matters:  |
|---|---|--|
| <b>Do I need a referral to see a <u>specialist</u>?</b> | Yes; You need written approval to see a specialist. There may be some providers or services for which referrals are not required. Please see the formal contract of coverage for details. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.         |
| <b>Are there services this plan doesn't cover?</b>      | Yes.  | Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <b><u>excluded services</u></b> . |



- **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 provider** 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 a Non-Network Provider                                | Limitations & Exceptions   |
|--|--|---|--|--|
| If you visit a health care provider's office or clinic   | Primary care visit to treat an injury or illness | \$30 copay  | Not covered  | -----none-----   |
|  | Specialist visit                                 | 10% coinsurance   | Not covered  | -----none-----   |
|  | Other practitioner office visit                  | <u>Chiropractor</u><br>10% coinsurance<br><u>Acupuncturist</u><br>Not covered               | <u>Chiropractor</u><br>Not covered<br><u>Acupuncturist</u><br>Not covered  | <u>Chiropractor</u><br>-----none-----<br><u>Acupuncturist</u><br>-----none-----  |
|  | Preventive care/screening/immunization           | No charge   | Not covered  | -----none-----   |
| If you have a test   | Diagnostic test (x-ray, blood work)              | <u>Lab - Office</u><br>10% coinsurance<br><u>X-Ray – Office</u><br>10% coinsurance          | <u>Lab - Office</u><br>Not covered<br><u>X-Ray – Office</u><br>Not covered | <u>Lab - Office</u><br>-----none-----<br><u>X-Ray – Office</u><br>-----none-----   |
|  | Imaging (CT/PET scans, MRIs)                     | 10% coinsurance   | Not covered  | Failure to obtain preauthorization may result in non-coverage or reduced coverage.   |
| If you need drugs to treat your illness or condition<br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.anthem.c">http://www.anthem.c</a> | Tier 1 - Typically Generic                       | \$15 copay per prescription (retail only) and \$38 copay per prescription (mail order only) | Not covered  | Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order program). No coverage for Non-Formulary prescription drugs. |
|  | Tier 2 - Typically Preferred/Formulary Brand     | \$40 copay per prescription (retail only) and \$100 copay per                               | Not covered  | Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order program). No coverage for Non-Formulary                     |

| Common Medical Event  | Services You May Need  | Your Cost if You Use an In-Network Provider                     | Your Cost if You Use a Non-Network Provider                 | Limitations & Exceptions   |
|---|--|---|---|--|
| <a href="#">om/pharmacyinformation/</a>                           |  | prescription (mail order only)                                  |   | prescription drugs.  |
|   | Tier 3 – Typically Non-preferred/Non-formulary and Specialty Drugs | 10% coinsurance (retail and mail order)                         | Not covered   | Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (mail order program). No coverage for Non-Formulary prescription drugs. Specialty drugs are limited to a 30 day supply. |
|   | Tier 4 -Typically Specialty Drugs                                  | Not applicable  | Not covered   | See Tier 3 Specialty drug benefits.  |
| <b>If you have outpatient surgery</b>                             | Facility fee (e.g., ambulatory surgery center)                     | 10% coinsurance   | Not covered   | Costs may vary by site of service. You should refer to your formal contract of coverage for details.   |
|   | Physician/surgeon fees   | \$30 copay for PCP/ 10% coinsurance for Specialist              | Not covered   | Copay applies per surgery performed. Cost share varies by provider specialty of the rendering physician.   |
| <b>If you need immediate medical attention</b>                    | Emergency room services  | \$200 copay and then deductible and 10% coinsurance             | \$200 copay and then deductible and 10% coinsurance         | Copay waived if admitted.  |
|   | Emergency medical transportation                                   | 10% coinsurance   | 10% coinsurance   | -----none-----   |
|   | Urgent care  | \$50 copay and then deductible and 10% coinsurance              | \$50 copay and then deductible and 10% coinsurance          | -----none-----   |
| <b>If you have a hospital stay</b>                                | Facility fee (e.g., hospital room)                                 | \$1,000 copay and then deductible and 10% coinsurance           | Not covered   | Failure to obtain preauthorization may result in non-coverage or reduced coverage.   |
|   | Physician/surgeon fee  | \$30 copay for PCP/ 10% coinsurance for specialist              | Not covered   | Copay applies per surgery performed. Cost share varies by provider specialty of the rendering physician.   |
| <b>If you have mental health, behavioral health, or substance</b> | Mental/Behavioral health outpatient services                       | <u>Mental/Behavioral Health Office Visit</u><br>10% coinsurance | <u>Mental/Behavioral Health Office Visit</u><br>Not covered | <u>Mental/Behavioral Health Office Visit</u><br>-----none-----   |

| Common Medical Event   | Services You May Need                       | Your Cost if You Use an In-Network Provider   | Your Cost if You Use a Non-Network Provider   | Limitations & Exceptions  |
|--|---|---|---|---|
| abuse needs  |   | <u>Mental/Behavioral Health Facility Visit-Facility Charges</u><br>10% coinsurance  | <u>Mental/Behavioral Health Facility Visit-Facility Charges</u><br>Not covered  | <u>Mental/Behavioral Health Facility Visit-Facility Charges</u><br>-----none-----   |
|  | Mental/Behavioral health inpatient services | \$1,000 copay and then deductible and 10% coinsurance   | Not covered   | Failure to obtain preauthorization may result in non-coverage or reduced coverage.  |
|  | Substance use disorder outpatient services  | <u>Substance Abuse Office Visit</u><br>10% coinsurance<br><u>Substance Abuse Facility Visit - Facility Charges</u><br>10% coinsurance | <u>Substance Abuse Office Visit</u><br>Not covered<br><u>Substance Abuse Facility Visit - Facility Charges</u><br>Not covered | <u>Substance Abuse Office Visit</u><br>-----none-----<br><u>Substance Abuse Facility Visit - Facility Charges</u><br>-----none-----   |
|  | Substance use disorder inpatient services   | \$1,000 copay and then deductible and 10% coinsurance   | Not covered   | Failure to obtain preauthorization may result in non-coverage or reduced coverage.  |
| If you are pregnant  | Prenatal and postnatal care                 | \$30 copay for PCP/<br>10% coinsurance for specialist   | Not covered   | Your doctor's charges for delivery are part of prenatal and postnatal care.   |
|  | Delivery and all inpatient services         | \$1,000 copay and then deductible and 10% coinsurance   | Not covered   | Failure to obtain preauthorization may result in non-coverage or reduced coverage. Applies to inpatient facility. Other cost shares may apply depending on services provided. |
| If you need help recovering or have other special health needs | Home health care                            | 10% coinsurance   | Not covered   | Coverage is limited to 40 visits per calendar year. Apply to In-Network Providers.  |
|  | Rehabilitation services                     | 10% coinsurance   | Not covered   | Coverage for physical therapy, occupational therapy and speech therapy combined is limited to 60 visits conditionlifetime. In-Network.  |
|  | Habilitation services                       | 10% coinsurance   | Not covered   | Coverage is limited to 680 hours per calendar year. Apply to In-Network   |

| Common Medical Event                          | Services You May Need     | Your Cost if You Use an In-Network Provider | Your Cost if You Use a Non-Network Provider | Limitations & Exceptions  |
|---|---------------------------|---|---|---|
|   |                           |   |   | Providers. Habilitation and Rehabilitation visits count towards your Rehabilitation limit.  |
|   | Skilled nursing care      | 10% coinsurance                             | Not covered                                 | Coverage is limited to 200 days per calendar year. Apply to In-Network Providers. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Costs may vary by site of service. You should refer to your formal contract of coverage for details. |
|   | Durable medical equipment | 10% coinsurance                             | Not covered                                 | -----none-----  |
|   | Hospice service           | 10% coinsurance                             | Not covered                                 | Coverage is limited to 210 days per calendar year. Apply to In-Network Providers.   |
| <b>If your child needs dental or eye care</b> | Eye exam                  | No charge                                   | Not covered                                 | Coverage is limited to 1 exam every 12 months. Apply to In-Network Providers.   |
|   | Glasses                   | No charge                                   | Not covered                                 | -----none-----  |
|   | 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Long-term care
- Most coverage provided outside the United States. See [www.bcbs.com/bluecardworldwide](http://www.bcbs.com/bluecardworldwide)
- Non-Formulary prescription drugs
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

### 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
- Chiropractic care
- Hearing aids: 20% Coinsurance; Limited to a single purchase (including repair/replacement) every three years
- Infertility treatment

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (855) 330-1104. You may also contact your state insurance department at:

New York State Department of Financial Services  
One State Street  
New York, NY 10004-1511  
(800) 342-3736  
(212) 480-6400  
(518) 474-6600

## 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:

ATTN: Grievances and Appeals  
Mail Drop R/6-O, P.O. Box 11825  
Albany, NY 12211

New York State Department of  
Financial Services  
One State Street  
New York, NY 10004-1511  
(800) 342-3736  
(212) 480-6400  
(518) 474-6600

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.**

## Language Access Services:

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。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íínízínigo t'áá diné k'éjígó, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béesh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'í hodiilní.

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.

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..

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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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## 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** \$3,300

#### 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          | \$1,000        |
| Copays               | \$2,000        |
| Coinsurance          | \$300          |
| Limits or exclusions | \$0            |
| <b>Total</b>         | <b>\$3,300</b> |

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact: [www.empireblue.com](http://www.empireblue.com) or (855) 330-1104.

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

- **Amount owed to providers:** \$5,400
- **Plan pays** \$3,700
- **Patient pays** \$1,700

#### 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          | \$1,000        |
| Copays               | \$500          |
| Coinsurance          | \$0            |
| Limits or exclusions | \$200          |
| <b>Total</b>         | <b>\$1,700</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: [www.empireblue.com](http://www.empireblue.com) or (855) 330-1104.

## 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, co-payments, 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?

**x 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?

**x 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.