




**This is only a summary.** If you want more detail about your prescription drug coverage and costs, you can get the complete terms in the policy or plan document at [www.bsneny.com](http://www.bsneny.com) or by calling 1-800-888-1238.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Does not apply	Does not apply
Are there other deductibles for specific services?	Does not apply	Does not apply
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network Pharmacy: \$1,650 Individual / \$3,300 Family	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 prescription drugs this plan may not 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.bsneny.com">www.bsneny.com</a> 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 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes. This does not cover health services, only prescription drugs.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions about your prescription coverage: Call 1-866-591-3878 or visit us at [www.bsneny.com](http://www.bsneny.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 <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-800-888-1238 to request a copy.

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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.

Common Medical Event	Services You May Need	Your Cost If You Use Retail Pharmacy	Your Cost If You Use an Out-of-network Pharmacy	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not applicable	Not applicable	This is a prescription drug only plan
	Specialist visit	Not applicable	Not applicable	This is a prescription drug only plan
	Other practitioner office visit	Not applicable	Not applicable	This is a prescription drug only plan
	Preventive care/screening/immunization	Not applicable	Not applicable	This is a prescription drug only plan
If you have a test	Diagnostic test (x-ray, blood work)	Not applicable	Not applicable	This is a prescription drug only plan
	Imaging (CT/PET scans, MRIs)	Not applicable	Not applicable	This is a prescription drug only plan
If you need drugs to treat your illness or condition  More information about <b>prescription drug coverage</b> is available at <a href="http://www.bsneny.com">www.bsneny.com</a> .	Generic drugs	\$5 co-pay/prescription	Not covered	\$10 co-pay per 90 day supply for mail order.
	Preferred brand drugs	\$20 co-pay/prescription	Not covered	\$40 co-pay per 90 day supply for mail order.
	Non-preferred brand drugs	\$35 co-pay/prescription	Not covered	\$70 co-pay per 90 day supply for mail order.
	Specialty drugs	See Limitations & Exceptions	Not covered	Specialty drugs could be generic, preferred brand, or non-preferred brand. For Member Service related to prescriptions call 1-866-591-3878.

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# BlueShield of Northeastern NY: ASO RX

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

Coverage Period: 07/01/2017 – 06/30/2018

Coverage for: Single/Family | Plan Type: RX

Common Medical Event	Services You May Need	Your Cost If You Use Retail Pharmacy	Your Cost If You Use an Out-of-network Pharmacy	Limitations & Exceptions
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not applicable	Not applicable	This is a prescription drug only plan
	Physician/surgeon fees	Not applicable	Not applicable	This is a prescription drug only plan
<b>If you need immediate medical attention</b>	Emergency room services	Not applicable	Not applicable	This is a prescription drug only plan
	Emergency medical transportation	Not applicable	Not applicable	This is a prescription drug only plan
	Urgent care	Not applicable	Not applicable	This is a prescription drug only plan
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not applicable	Not applicable	This is a prescription drug only plan
	Physician/surgeon fee	Not applicable	Not applicable	This is a prescription drug only plan
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Not applicable	Not applicable	This is a prescription drug only plan
	Mental/Behavioral health inpatient services	Not applicable	Not applicable	This is a prescription drug only plan
	Substance use disorder outpatient services	Not applicable	Not applicable	This is a prescription drug only plan
	Substance use disorder inpatient services	Not applicable	Not applicable	This is a prescription drug only plan
<b>If you are pregnant</b>	Prenatal and postnatal care	Not applicable	Not applicable	This is a prescription drug only plan
	Delivery and all inpatient services	Not applicable	Not applicable	This is a prescription drug only plan
<b>If you need help recovering or have other special health needs</b>	Home health care	Not applicable	Not applicable	This is a prescription drug only plan
	Rehabilitation services	Not applicable	Not applicable	This is a prescription drug only plan
	Habilitation services	Not applicable	Not applicable	This is a prescription drug only plan
	Skilled nursing care	Not applicable	Not applicable	This is a prescription drug only plan
	Durable medical equipment	Not applicable	Not applicable	This is a prescription drug only plan
	Hospice service	Not applicable	Not applicable	This is a prescription drug only plan
<b>If your child needs dental or eye care</b>	Eye exam	Not applicable	Not applicable	This is a prescription drug only plan
	Glasses	Not applicable	Not applicable	This is a prescription drug only plan
	Dental check-up	Not applicable	Not applicable	This is a prescription drug only plan

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If you are pregnant	Prenatal and postnatal care	Not applicable	Not applicable	This is a prescription drug only plan
	Delivery and all inpatient services	Not applicable	Not applicable	This is a prescription drug only plan
If you need help recovering or have other special health needs	Home health care	Not applicable	Not applicable	This is a prescription drug only plan
	Rehabilitation services	Not applicable	Not applicable	This is a prescription drug only plan
	Habilitation services	Not applicable	Not applicable	This is a prescription drug only plan
	Skilled nursing care	Not applicable	Not applicable	This is a prescription drug only plan
	Durable medical equipment	Not applicable	Not applicable	This is a prescription drug only plan
	Hospice service	Not applicable	Not applicable	This is a prescription drug only plan
If your child needs dental or eye care	Eye exam	Not applicable	Not applicable	This is a prescription drug only plan
	Glasses	Not applicable	Not applicable	This is a prescription drug only plan
	Dental check-up	Not applicable	Not applicable	This is a prescription drug only plan

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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
- Bariatric surgery
- Chiropractic care
- Cosmetic Surgery
- Custodial care
- Dental Care
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Private-duty nursing
- 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.)

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.

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### 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 1-800-888-1238. 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: 1-800-888-1238.

### 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 1-800-888-1238.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-888-1238.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-888-1238.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-888-1238.

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

**Questions about your prescription coverage:** Call 1-866-591-3878 or visit us at [www.bsneny.com](http://www.bsneny.com).

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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 \$90
- Patient pays \$7,450

#### 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	\$10
Coinsurance	\$0
Limits or exclusions	\$7,440
<b>Total</b>	<b>\$7,450</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$2,560
- Patient pays \$2,840

#### 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	\$200
Coinsurance	\$0
Limits or exclusions	\$2,640
<b>Total</b>	<b>\$2,840</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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## Notice of nondiscrimination

BlueShield of Northeastern New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BlueShield of Northeastern New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BlueShield of Northeastern New York:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the customer service number on the back of your ID card or contact Carleen Dunne, Director, Corporate Compliance & Privacy Officer.

If you believe that BlueShield of Northeastern New York has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Carleen Dunne, Director, Corporate Compliance & Privacy Officer, 257 W Genesee St., Buffalo, NY 14202, 716-887-8624, 716-887-6056, [dunne.carleen@bsneny.com](mailto:dunne.carleen@bsneny.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Michele Salerno, Regulatory Compliance Manager is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-888-1238 (TTY: 711).**

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-888-1238 (TTY: 711).

**注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-888-1238 (TTY: 711)。

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-888-1238 (телетайп: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-888-1238 (TTY: 711).

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-888-1238 (TTY: 711)번으로 전화해 주십시오.

**ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-888-1238 (TTY: 711).

**אויפמערקזאם:** אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-888-1238 (TTY: 711).

**লক্ষ্য করুন:** যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-৮০০-৮৮৮-১২৩৮ (TTY: ৭১১)।

**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-888-1238 (TTY: 711).

**ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-888-1238 (رقم هاتف الصم والبكم: 711).

**ATTENTION :** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-888-1238 (ATS : 711).

**خبردار:** اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-800-888-1238 (TTY: 711)۔

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-888-1238 (TTY: 711).

**ΠΡΟΣΟΧΗ:** Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-888-1238 (TTY: 711).

**KUJDES:** Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-888-1238 (TTY: 711).