Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Excellus BCBS: Classic Blue

A nonprofit independent licensee of the BlueCross BlueShield Association

IBEW 139 Local Welfare Fund Coverage Period:07/01/2020 - 06/30/2021

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-499-1275 or visit Our website at www.excellusbcbs.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 Individual/$750 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible ?	No	You will have to meet the deductible before the plan pays for any services
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000 Individual/$0 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits
What is not included in the out-of-pocket limit?	Costs for penalties for failure to obtain preauthorization for services, premiums, balance billing 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.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	20% Coinsurance	None
	Specialist visit	20% Coinsurance	20% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: 20% Coinsurance Adult Immunizations: 20% Coinsurance Well Child Visit: 20% Coinsurance	Adult Physical: 20% Coinsurance Adult Immunizations: 20% Coinsurance Well Child Visit: 20% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 1 Exam per year
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	20% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	20% Coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.excellusbcbs.com	Tier 1 (Generic drugs)	20% Coinsurance	20% Coinsurance	None
	Tier 2 (Preferred brand drugs)	20% Coinsurance	20% Coinsurance	
	Tier 3 (Non-preferred brand drugs)	20% Coinsurance	20% Coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Physician/surgeon fees	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need immediate medical attention	Emergency room care	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	No Charge Deductible does not apply	No Charge Deductible does not apply	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Physician/surgeon fees	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	20% Coinsurance	None
	Inpatient services	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you are pregnant	Office visits	No Charge Deductible does not apply	No Charge Deductible does not apply	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge Deductible does not apply	No Charge Deductible does not apply	None
	Childbirth/delivery facility services	No Charge Deductible does not apply	No Charge Deductible does not apply	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	20% Coinsurance	40 Visits per year limit
	Rehabilitation services	20% Coinsurance	20% Coinsurance	None
	Habilitation services	20% Coinsurance	20% Coinsurance	
	Skilled nursing care	20% Coinsurance	20% Coinsurance	
	Durable medical equipment	20% Coinsurance	20% Coinsurance	
	Hospice services	Not Covered	Not Covered	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Cosmetic surgery	• Dental care (Adult)

• Dental care (Child)	• Hearing aids	• Hospice services
• Infertility Treatment	• Long-term care	• Private-duty nursing
• Routine eye care (Adult)	• Routine eye care (Child)	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Chiropractic care	• Non-emergency care when traveling outside the U.S.
• Routine foot care		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or www.excellusbcbs.com; 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 the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$250**
- **Coinsurance** **20%**
- **Hospital (facility) copayment** **$0**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,820**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$210
What isn't covered	
Limits or exclusions	$80
The total Peg would pay is	**$540**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$250**
- **Coinsurance** **20%**
- **Hospital (facility) copayment** **$0**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,350
What isn't covered	
Limits or exclusions	$370
The total Joe would pay is	**$1,970**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$250**
- **Coinsurance** **20%**
- **Hospital (facility) copayment** **$0**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$220
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$470**

Your Health Reimbursement Account (HRA) may be available for reimbursement for out-of-pocket expenses

The **plan** would be responsible for the other costs of these EXAMPLE covered services.