East End Health Plan

Coverage Period: July 1, 2016 to June 30, 2017

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

Plan Type: BCBS 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.eehp.org or by calling 1-844-230-4720 for questions pertaining to your medical benefits and 888-219-6886 for questions pertaining to your prescription drug benefits

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$0** Individual / **$0** Family Non-Network: **$1,000** Individual / $1,000 Spouse / **$1,000** for all dependent children combined per calendar year. Does not apply to copays, prescription drugs, and services listed below as "No Charge".	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The deductible starts January 1st of each year and applies to the calendar year. See the Common Medical Events chart for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services, but see the Common Medical Events chart for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Network: **$0** Individual / **$0** Family Non-Network: **$3,000** Individual / $3,000 Spouse / **$3,000** for all dependent children combined per calendar year.	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?	Premium, deductibles, prescription drugs, copays, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain Pre-Notification for services.	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 Common Medical Events chart 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, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see www.empireblue.com\eehp or call 1-844-230-4720 for a list of network providers.	If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the Common Medical Events chart for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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 under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about excluded services.

Questions: Call 1-844-230-4720 for questions pertaining to your medical benefits and 888-219-6886 for questions pertaining to your prescription drug benefits or visit us at www.eehp.org. 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.dol.gov/ebsa/healthreform or call the phone number above to request a copy.

- **Copayments** are fixed dollar amounts (for example, $20) 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 a		Limitations & Exceptions
		Network Provider	a Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	20% co-insurance, after deductible.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$20 copay per visit	20% co-insurance, after deductible.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$20 copay per visit of Manipulative (Chiropractic) services, $20 copay for related radiology	50% of network allowance for Manipulative (Chiropractic) services, after deductible.	Manipulative (Chiropractic) services are unlimited per Calendar year.
	Preventive care/screening/immunization	No Charge	20% co-insurance, after deductible	Includes preventive health services specified in the health care reform law. *Deductible/co-ins may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% co-insurance, after deductible	None
	Imaging (CT/PET scans, MRIs)	$20 copay per service	20% co-insurance, after deductible	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Generic drugs	Retail: $5 copay Mail-Order: $10 copay	Not Covered	Charges for the following services and/or supplies are NOT covered prescription drug expenses: Viagra and other impotency drugs in excess of 6 pills per insured per month. • Vitamins. **Exceptions:** Calcitrol (e.g. Rocaltrol), Calcifediol (e.g. Calderol), and Dihydrotachysterol (e.g. Hytakerol) are covered. • Cosmetic drugs including, but not limited to, hair removal products and hair growth stimulants. • Non-legend (over the counter) drugs other than insulin. • Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original script. • Prescription Medications that are classified as Proton Pump Inhibitors including Omeprazole, Pantoprazole, Nexium, Aciphex, Prevacid, and Protonix.
	Preferred brand drugs	Retail: $25 copay Mail-Order: $50 copay	Not Covered	
	Non-preferred brand drugs	Retail: $45 copay Mail-Order: $90 copay	Not Covered	
	Specialty drugs	20% copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 copay per visit	20% co-insurance, after deductible	None
	Physician/surgeon fees	No Charge	20% co-insurance, after deductible	None

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	a Non-Network Provider	
If you need immediate medical attention	Emergency room services	$50 copay per visit	Same as Network	Copay is waived if you are admitted for Inpatient stay directly from the Emergency Room.
	Emergency medical transportation	$50 copay	Same as Network	None
	Urgent care	$20 copay per visit	20% co-insurance, after deductible	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% co-insurance, after deductible	Unlimited day limit monitored by Care Coordination Process in lieu of 365 day maximum. Pre-Notification is required or penalty up to $200.
	Physician/surgeon fee	No Charge	20% co-insurance, after deductible	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Individual: $20 copay per visit Group: $20 copay per visit	20% co-insurance, after deductible	None
	Mental/Behavioral health inpatient services	No Charge	20% co-insurance, after deductible	None
	Substance use disorder outpatient services	Individual: $20 copay per visit Group: $20 copay per visit	20% co-insurance, after deductible	None
	Substance use disorder inpatient services	No Charge	20% co-insurance, after deductible	None
If you are pregnant	Prenatal and postnatal care	$20 copay	20% co-insurance, after deductible	Additional copays, deductibles, or co-insurance may apply. Network routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	No Charge	20% co-insurance, after deductible	None

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Network Provider	a Non-Network Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Limited to 100 visits per Calendar year.
	Rehabilitation services	$20 copay per outpatient visit	20% co-insurance, after deductible	Outpatient rehabilitation services are unlimited per Calendar year.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.
	Skilled nursing care	No Charge	No Charge	Limited to 90 visits per Calendar year.
	Durable medical equipment	10% co-insurance	20% co-insurance, after deductible	Pre-notification is required for equipment of more than $1,000
	Hospice service	No Charge	No Charge	Unlimited maximum both In and Out of Network.
If your child needs dental or eye care	Eye exam	No Charge	Covered per Fee Schedule	Coverage through Davis Vision
	Glasses	No Charge	Covered per Fee Schedule	Coverage through Davis Vision
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

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.)

- Cosmetic surgery
- Dental care (Adult/Child)
- Habilitation services
- Long-term care
- 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.)

- Acupuncture - may be covered with limitations
- Bariatric surgery
- Chiropractic care - may be covered with limitations
- Hearing aids - may be covered with limitations
- Infertility Treatments (medical expneses up to $35,000 per year, no limitation on drugs)
- Private-duty nursing - may be covered with limitations

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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 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit 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 the Member Service number listed on the back of your ID card or visit www.myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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.**

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 1-844-230-4720.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-230-4720.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-844-230-4720.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-230-4720.

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** $7,440
- **Patient pays** $100

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	$0
Copays	$100
Coinsurance	$0
Limits or exclusions	$0
Total	**$100**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,160
- **Patient pays** $240

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	$
Copays	$240
Coinsurance	$
Limits or exclusions	$
Total	**$240**

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.