

# City of Plattsburgh BENEFITS ENROLLMENT GUIDE



**PLAN YEAR 2015**



# Benefits Directory

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# How to Enroll in Benefits

## MEDICAL

### **BlueShield of Northeastern NY**

*Customer Service Department*

Phone: 888-840-6322

Website: [www.bsneny.com](http://www.bsneny.com)

Pharmacy ProAct Help Desk: 877-635-9545

Health Direct (mail order): 866-287-9885

## DENTAL (POS PLANS)

### **BlueShield of Northeastern NY**

*Customer Service Department*

Phone: 888-840-6322

Web: [www.bsneny.com](http://www.bsneny.com)

## VISION (POS PLANS)

### **Davis Vision**

Phone: 800-999-5431

Web: [www.davisvision.com](http://www.davisvision.com)

## FSA – FLEXIBLE SPENDING ACCOUNTS

### **EBS/RMSCO**

*Contact: Karen Rulfs, First Niagara*

Phone: 518-324-5335

Email: [karen.rulfs@fnrm.com](mailto:karen.rulfs@fnrm.com)

## NEW YORK STATE DISABILITY

### **Dearborn National**

Submit Claims To: Ann Giard-Chase, PHR

Human Resources, 41 City Hall Place

Plattsburgh, NY 12901

Email: [chasea@cityofplattsburgh-ny.gov](mailto:chasea@cityofplattsburgh-ny.gov)

## EAP – EMPLOYEE ASSISTANCE PROGRAM

### **Behavioral Health Service North**

Website: [www.bhsn.org](http://www.bhsn.org)

### **Who is Eligible and When:**

If you are a City of Plattsburgh full-time employee working at least 35 or more hours per week and you have satisfied your 30 day probationary period you may be eligible to enroll in the benefits described in this guide.

The following family members are eligible for medical coverage through the City of Plattsburgh: Spouse and dependent (married or unmarried) until dependent's 26<sup>th</sup> birthday for medical. For the POS 298 dental and vision; to the dependent's 26<sup>th</sup> birthday.

### **How to Enroll:**

The first step is to review your current benefit elections. Verify your personal information and make any changes if necessary. Make your benefit elections. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

### **When to Enroll:**

The open enrollment period runs from June 1, 2014 through June 25, 2014 and December 1, 2014 through December 31, 2104. The benefits you elect during open enrollment will be effective from January 1, 2015 through December 31, 2015.

### **How to Make Changes:**

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period.

Qualified changes in status include: marriage, divorce, legal separation, domestic partnership status change, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse or domestic partner, commencement or termination of adoption proceedings, or change in spouse's or domestic partner's benefits or employment status.

# Ways to Save on Healthcare Costs and Stay Healthy!

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## ❑ **Practice Prevention**

Annual physicals, screenings and immunizations help you stay healthy and may help you avoid or delay health problems, which tend to cost more to treat.

## ❑ **Use In-Network Providers**

Providers who are “In-Network” provide services at a discounted rate. Referrals are required for all Vermont appointments and procedures including lab & X-ray.

## ❑ **Manage Your Health**

Utilize the Blue Shield website ([www.bsny.com](http://www.bsny.com)) for information on numerous Health Topics!

## ❑ **Use the Emergency Room for Emergencies Only**

Save the emergency room for true emergencies (life-threatening illness and injuries). If your doctor is not available for less severe health events, consider using an urgent care facility.

## ❑ **Enroll in a Health Care Flexible Spending Account**

Set money aside on a pre-tax basis to pay for predictable medical, dental and vision expenses.

## ❑ **Get Annual Eye Exams**

Annual eye exams not only help correct vision problems but also reveal warning signs of more serious undiagnosed health problems such as hypertension, cardiovascular disease and diabetes. Eye exams are important to your productivity and overall health!



# Ways to Save on Prescription Costs and Stay Healthy!

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## ❑ Practice Prevention

Annual physicals, screenings and immunizations help you stay healthy and may help you avoid or delay health problems, which tend to cost more to treat.

## ❑ Manage Your Health

Utilize Blue Shield website [www.bsny.com](http://www.bsny.com) for information on numerous Health Topics!

## ❑ Ask for Generics

Generics have the same active ingredients as brand name drugs, but cost significantly less.

## ❑ Use Mail Order for Maintenance Meds

If you are on maintenance medications (you take the medication for more than 90 days), use mail order through ProAct

## ❑ Use CanaRx for Brand Name Maintenance Meds

If your physician prescribes a maintenance BRAND NAME drug instead of a generic, you can save because there is \$0 Copay for BRAND NAME DRUGS through CanaRX. Go to [www.plattsburghmeds.com](http://www.plattsburghmeds.com) for information and enrollment.

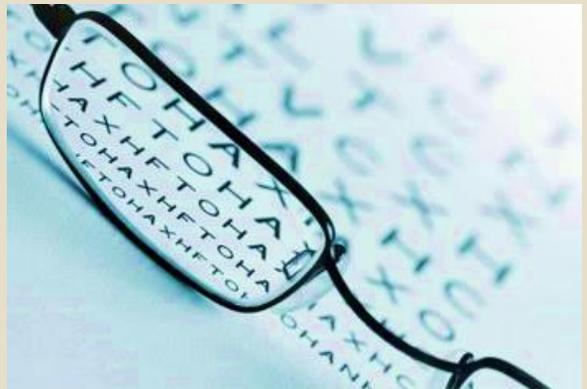
## ❑ Enroll in a Health Care Flexible Spending Account

Set money aside on a pre-tax basis to pay for co-pays on prescription costs.



# MEDICAL, PRESCRIPTION, DENTAL, VISION, and OTHER BENEFITS

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SUBJECT	DESCRIPTION	FORMS ATTACHED	CONTACT /SUBMIT FORMS TO
<b>Medical, Rx and Drug Benefits</b> <i>BlueShield of NENY ProAct</i>	<b>ENROLLMENT FORM OR WAIVER FORM</b> Enrollment in Medical and Prescription Drug Benefit coverage is mandatory for Permanent/Full Time employees. Waiver Form is used if employee has coverage and wants the buy-out instead (see CBAs).		Contact Karen Rulfs @ First Niagara 518.324.5355
<b>Plattsburgh Meds Benefit</b> <i>CanaRx</i>	<b>OPTIONAL ENROLLMENT</b> International RX Drug Mail-Order Program: This is an optional international prescription drug mail order program designed for the City employee, retiree, and their dependents through CanaRx. \$0 co-pay for Brand Name Drugs (90 days supply). You save between \$30-60 per script for Preferred Brand medications and between \$75-\$120 per script for Non-Preferred Brand medications. Generic medications are not available through this program.		Contact Karen Rulfs @ First Niagara 518.324.5355
<b>Vision Benefit</b> <i>Davis Vision</i>	<b>OPTIONAL ENROLLMENT</b> For those employees enrolled in the POS 298 Medical and Prescription Drug Benefit plans only, vision benefits are provided through Davis Vision.		Contact Karen Rulfs @ First Niagara 518.324.5355
<b>Flexible Spending Accounts (FSA) Benefit</b>	<b>OPTIONAL BENEFIT</b>  <u>Healthcare Component – Maximum \$2550:</u> This account helps you save money on IRS-qualified-out-of-pocket medical expenses such as copays, coinsurance, prescriptions, dental services, etc. Application Form included in Kit  <u>Dependent Care Component – Maximum \$5000:</u> This FSA account helps you save money on daycare expenses for dependent children and adults so you can work. Application Form included in Kit.  <i>A ‘use it or lose it’ provision applies to both of these accounts. Any amounts remaining in the accounts at the end of the plan year will be forfeited.</i>	<b>Enrollment Form</b>  <b>Direct Deposit Form</b>  <b>Reimbursement Request Form</b>	Submit completed forms to Karen Rulfs @ First Niagara 518.324.5355
<b>Short Term Disability Benefit</b> <i>Dearborn National</i>	<b>NON-WORK RELATED INJURY OR ILLNESS BENEFIT</b> The City provides all employees with short term disability income benefits and pays the full cost, (except for Level 3 Managers) of this coverage. In the event you become disabled from a NON-work-related injury or illness, disability income benefits are provided (after a 7 day waiting period) as a source of income for up to 26 weeks and replaces 50% of income. The maximum benefit is \$170 per week. You are not eligible to receive short-term disability benefits if you are receiving workers’ compensation benefits.		Submit completed forms to Ann Giard-Chase, PHR @ HR 41 City Hall Place 518.536.7527

SUBJECT	DESCRIPTION	FORMS ATTACHED	CONTACT /SUBMIT FORMS TO
<b>AFLAC Supplementary Insurance Benefit</b>	<p><b>OPTIONAL BENEFIT</b> The City of Plattsburgh offers you the opportunity to purchase additional affordable Short-Term Disability Insurance, Specified-Disease Insurance, 24-Hour Accident-Only Insurance, Life Insurance, and Dental Insurance.</p> <p>These policies are purchased through Aflac on a pre-tax, payroll deducted basis. There are different levels of plans that you can choose from. The policies are portable. Should you leave the City of Plattsburgh, you can take the policies with you at the exact same cost.</p>		<p>Contact Jessie Jennett @ Aflac 518.578.2464 jessie_jennett @us.aflac.com</p>
<b>Fitness Benefit</b>	<p><b>OPTIONAL BENEFIT - FREE MEMBERSHIP</b> The City offers employees free use of the City Recreation Facility Gym located on the base oval for their fitness needs. Employee's dependent' gym fees are as follows: Spouses=\$10/month, Children=\$10/month up to 2 children (Under 12 are free and must be accompanied by a parent). If interested, sign up at Rec Dept.</p>		<p>Contact Gail Williams @ Rec Dept 518.536.7462</p>
<b>EAS - Employee Assistance Services</b> <i>Behavioral Health Service North</i>	<p><b>OPTIONAL BENEFIT</b> <b>See your CBA for terms and provisions</b> The City offers its employees and their immediate family members confidential counseling/support services through Behavioral Health (EAS), an employee assistance firm. The counseling program covers issues such as marital and family concerns, depression, substance abuse, grief and loss, financial entanglements, and other personal stressors.</p>		

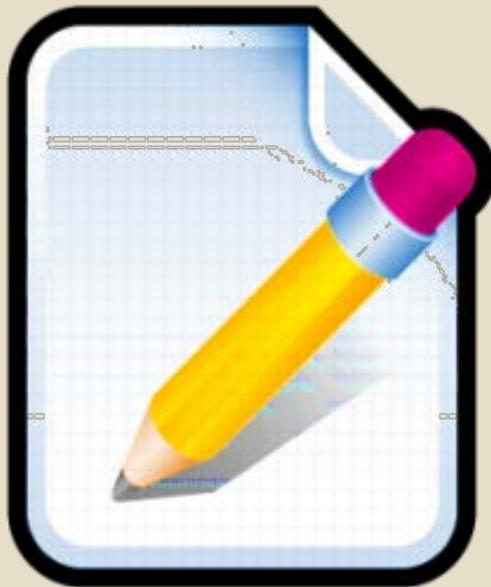
# FORMS

The Maximum dollar amount that you can contribute to the FSA Account (Health Care Component) in 2015 is \$2550.

The Maximum dollar amount that you can contribute to the FSA Account (Dependent Care Component) in 2015 is \$5000.

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- **FSA ENROLLMENT FORM**
- **FSA REIMBURSEMENT REQUEST FORM**





# Flexible Spending Account Enrollment Form

Employer Name: \_\_\_\_\_

Participant Name (First, MI, Last): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City, ST, ZIP: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_

Email Address: \_\_\_\_\_

FSA Benefit Election	Per Pay Period Amount	Total Annual Amount	# Pays Per Year
<input type="checkbox"/> Health Care Election—Standard	\$	\$	
<input type="checkbox"/> Health Care Election—Limited	\$	\$	
<input type="checkbox"/> Dependent Care Election	\$	\$	

### Carrier Information.

Check the boxes if you are enrolled in any of these benefits through your employer.  Medical;  Dental;  Vision;  Rx  
**Automated Claims Transfer:** If you are eligible for ACT (check with your Employer), certain expenses submitted through your insurance provider may automatically be reimbursed to you, unless you or any of your dependents have Coordination of Benefits (COB) with other Plans. This feature is not applicable to Health Spending Card holders.

I do not want ACT or I have COB and am not eligible for ACT.

**Spouse/Dependent Information (Attach additional pages if necessary)**  I do not have a spouse or dependents

Name	Social Security Number	Date of Birth	Gender	Relationship

### Direct Deposit Election (Complete this section if you want Direct Deposit of your reimbursements)

Type of Account (Check one):  Checking  Savings

Name of Bank: \_\_\_\_\_

Transit ABA Routing #: \_\_\_\_\_ Account #: \_\_\_\_\_

### Participant Authorization—Return signed form to your Employer.

By signing below I agree to participate in my employer's pre-tax program and certify that I understand and will comply with the regulations governing such Plan. I understand the basic provisions provided on page 2 of this form are guidelines only and that my Plan's Summary Plan Descriptions prevails.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### To Be Completed by the Employer

New Hire  Open Enrollment Effective Date: \_\_\_\_\_

First Payroll Deduction Date: \_\_\_\_\_

- Notify Payroll of deduction amount and date
- Keep copy of Enrollment Form for your records
- Forward copy of Enrollment Form or provide data on a file to Lifetime Benefit Solutions

**This Plan has employer funded money:**  Yes  No. **If Yes,**

ER Money:	Payroll Based?	Annual Amount
<input type="checkbox"/> Health Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
<input type="checkbox"/> Dependent Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$

# ▶ Reimbursement Request Form

Employer Name: \_\_\_\_\_

Participant Name (First, MI, Last): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City, ST, ZIP: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

**Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.**

Claimant Name	Date of Service	Amount	Plan Code*	Type of Service/Item Purchased	# of Miles	Claim Ref #
<i>John Sample</i>	<i>10/1/2014</i>	<i>\$ 150.25</i>	<i>F</i>	<i>Doctor visit copay</i>	<i>12</i>	<i>Example</i>
		\$				01
		\$				02
		\$				03
		\$				04
		\$				05
		\$				06

Use one of the Plan Code's below to indicate the account from which payment should be made. Your employer may not offer all the benefit types listed below and certain restrictions may apply. If your employer offers multiple benefit types, Lifetime Benefit Solutions will process the reimbursement based on the rules established by your employer. For example, if you have both an FSA and HRA account, and your employer has identified the FSA as the "pay first" account, your expenses will be applied to your FSA until the balance is depleted with any additional expenses applied to your HRA.

*Plan Code	Plan Code Description
F	Flexible Spending Account (FSA) or Limited Purpose FSA: Health Care Expenses Only. For Dependent Care expenses, use the Dependent Care Account Reimbursement Request Form
H	Health Reimbursement Account (HRA) or Retiree Reimbursement Account (RRA)
P	Parking Account (cannot claim miles associated with Parking)
T	Transit Account (cannot claim miles associated with Transit)
I	Individual Insurance Policy Premiums
M	To submit for medical mileage associated with Health Spending Card transactions. You will only be reimbursed for the medical mileage associated with the miles traveled, since you paid for the service with the Health Spending Card.

By submitting this form to Lifetime Benefit Solutions, I certify the information is accurate, the expenses incurred were for myself, spouse or qualified dependents, and these expenses are not reimbursable under any other plan coverage. In addition, I have read the Reimbursement Request Instructions on the following page and agree to adhere to all terms specified. I understand if I do not follow the instructions my reimbursement may be delayed or denied.

- **Mail to:** Lifetime Benefit Solutions, Claims Dept, PO Box 6509, Syracuse, NY 13217
- **Fax to:** 877-256-7228
- Call **Customer Service** with questions at 800-327-7130



# MEDICAL AND RX PLAN OPTIONS

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- TRADITIONAL PLAN (0001 & 0002)
- POS 298 PLAN (0003)
- POS 298 PLAN (0004)
- POS 298 PLAN (0005 & 0006)
- POS 298 PLAN (0007)



# Medical and Prescription Drug Benefits

## TRADITIONAL PLAN (0001 & 0002)

Below is a brief outline of the Self Insured Traditional plan available to full time employees of the City of Plattsburgh. You may obtain a more detailed Benefit Summary of this plan from Karen Rulfs @ First Niagara.

Services – Traditional Plan (0001 & 0002)	In-Network	Out-of-Network
Deductible	Combined in and out of network; \$100 Individual / \$200 Family	
Coinsurance	20%	20%
Out of Pocket Maximum	Combined in and out of network; \$500	
Office Visit Copay	Subject to Deductible & Coinsurance	Subject to Deductible & Coinsurance
Adult Routine Physical Exams (age 50 & older for the employee/retiree – no dependents)	BlueShield pays \$50 towards the cost of the appointment	BlueShield pays \$50 towards the cost of the appointment
Mammography	Covered in full	Covered in full
Pap Smear	Covered in full	Covered in full
Routine GYN Exam	Covered in full	Covered in full
Prostate Cancer Screening	Covered in full	Covered in full
In-Patient Hospital Benefits	Covered in full	Covered in full
Out-Patient Surgery	Covered in full	Covered in full
Urgent Care	Subject to Deductible & Coinsurance	Subject to Deductible & Coinsurance
Emergency Room	Covered in full	Covered in full
Diagnostic X-Rays	Covered in full	Covered in full
Diagnostic Laboratory and Pathology	Covered in full	Covered in full
<b>PROACT Prescription Drug</b> – Retail Pharmacy 30 days <b>PROACT Maintenance Drug</b> —Mandatory mail order, (Maintenance = a Rx of 90 days with 2 copays) <b>CanaRx</b> —\$0 Copay, Mail Order, 90 days,, BRAND NAME drugs only	\$0 Generic \$10 Preferred Brand \$10 Non Preferred Brand	\$0 Generic \$10 Preferred Brand \$10 Non Preferred Brand

### PAYROLL DEDUCTIONS (48 PAY PERIODS) FOR 2015

TRADITIONAL PLAN	Employee Only	Family	Single Medicare	Family Medicare
<b>Self Insured</b>	<b>\$ 34.41</b>	<b>\$ 82.29</b>	<b>\$34.41</b>	<b>\$82.29</b>



**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.bsneny.com](http://www.bsneny.com) or by calling 1-888-840-6322.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	None	See the chart starting on page 2 for your costs for services this plan covers.
<b>Are there other deductibles for specific services?</b>	Yes. Major Medical Deductible: \$100 Individual/\$200 Family	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.
<b>Is there an out-of-pocket limit on my expenses?</b>	No	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	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.
<b>Does this plan use a network of providers?</b>	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 <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-888-840-6322 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 1-888-840-6322 to request a copy.

Group ID: 00962347  
Class: 0001 20150105

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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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	20% co-insurance	
	Specialist visit	20% co-insurance	20% co-insurance	
	Other practitioner office visit	20% co-insurance for chiropractor, Not Covered for acupuncture	20% co-insurance for chiropractor, Not Covered for acupuncture	
	Preventive care/screening/immunization	\$0 co-pay/visit for mammogram	\$0 co-pay/visit for mammogram	Refer to Summary Plan Description for covered preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-insurance	0% co-insurance	
	Imaging (CT/PET scans, MRIs)	0% co-insurance	0% co-insurance	
If you need drugs to treat your illness or condition	Generic drugs	\$0 co-pay/prescription	\$0 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
	Preferred brand drugs	\$10 co-pay/prescription	\$10 co-pay/prescription	\$20 co-pay applies to the Mandatory mail order.
More information about <u>prescription</u>	Non-preferred brand drugs	\$10 co-pay/prescription	\$10 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Group ID: 00962347  
Class: 0001 20150105

# BlueShield of Northeastern NY: Traditional Blue 998

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

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: Indemnity

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<u>drug coverage</u> is available at <a href="http://www.bsneny.com">www.bsneny.com</a> .	Specialty drugs	See Limitations & Exceptions	See Limitations & Exceptions	Please contact your Pharmacy Benefits Manager for more detail.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% co-insurance	0% co-insurance	
	Physician/surgeon fees	0% co-insurance	0% co-insurance	
<b>If you need immediate medical attention</b>	Emergency room services	0% co-insurance	0% co-insurance	
	Emergency medical transportation	0% co-insurance	0% co-insurance	20% co-insurance for Ambulette, Air and Volunteer Ambulance services
	Urgent care	20% co-insurance	20% co-insurance	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% co-insurance	0% co-insurance	
	Physician/surgeon fee	0% co-insurance	0% co-insurance	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	20% co-insurance	20% co-insurance	
	Mental/Behavioral health inpatient services	0% co-insurance	0% co-insurance	
	Substance use disorder outpatient services	0% co-insurance	0% co-insurance	
	Substance use disorder inpatient services	0% co-insurance	0% co-insurance	
<b>If you are pregnant</b>	Prenatal and postnatal care	0% co-insurance	0% co-insurance	
	Delivery and all inpatient services	0% co-insurance	0% co-insurance	

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Group ID: 00962347  
Class: 0001 20150105

# BlueShield of Northeastern NY: Traditional Blue 998

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

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: Indemnity

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<b>If you need help recovering or have other special health needs</b>	Home health care	0% co-insurance	0% co-insurance	
	Rehabilitation services	0% co-insurance	0% co-insurance	
	Habilitation services	0% co-insurance	0% co-insurance	
	Skilled nursing care	\$0 co-pay/visit	\$0 co-pay/visit	
	Durable medical equipment	20% co-insurance	20% co-insurance	
	Hospice service	0% co-insurance	0% co-insurance	
<b>If your child needs dental or eye care</b>	Eye exam	See limitations and exceptions	See limitations and exceptions	Member cost share will vary. Refer to your Summary Plan Description for coverage details.
	Glasses	Not covered	Not covered	
	Dental check-up	See limitations and exceptions	See limitations and exceptions	Member cost share will vary. Refer to your Summary Plan Description for coverage details.

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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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
- Cosmetic Surgery
- Custodial care
- Dental care (Adult)
- Hearing aids
- Long-term care
- 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.)

- Bariatric surgery
- Non-emergency care when traveling outside the United States
- Chiropractic care
- Infertility treatment

**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.**

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Group ID: 00962347  
Class: 0001 20150105

## 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 1-888-840-6322. 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: 1-888-840-6322.

## 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.**

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Spanish (Español): Para obtener asistencia en Español, llame al 1-888-840-6322.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-840-6322.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-840-6322.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-840-6322.

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

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Group ID: 00962347  
Class: 0001 20150105

## 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 \$7,270**
- **Patient pays \$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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$100
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$170
<b>Total</b>	<b>\$270</b>

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$1,930**
- **Patient pays \$3,470**

#### 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	\$100
Copays	\$0
Coinsurance	\$440
Limits or exclusions	\$2,930
<b>Total</b>	<b>\$3,470</b>

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Group ID: 00962347  
 Class: 0001 20150105

## 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.

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Group ID: 00962347  
Class: 0001 20150105



**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.bsneny.com](http://www.bsneny.com) or by calling 1-888-840-6322.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	None	See the chart starting on page 2 for your costs for services this plan covers.
<b>Are there other deductibles for specific services?</b>	Yes. Major Medical Deductible: \$100 Individual/\$200 Family	You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.
<b>Is there an out-of-pocket limit on my expenses?</b>	No	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	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.
<b>Does this plan use a network of providers?</b>	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 <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .

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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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	20% co-insurance	
	Specialist visit	20% co-insurance	20% co-insurance	
	Other practitioner office visit	20% co-insurance for chiropractor, Not Covered for acupuncture	20% co-insurance for chiropractor, Not Covered for acupuncture	
	Preventive care/screening/immunization	\$0 co-pay/visit for mammogram	\$0 co-pay/visit for mammogram	Refer to Summary Plan Description for covered preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	0% co-insurance	0% co-insurance	
	Imaging (CT/PET scans, MRIs)	0% co-insurance	0% co-insurance	
If you need drugs to treat your illness or condition	Generic drugs	\$0 co-pay/prescription	\$0 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
	Preferred brand drugs	\$10 co-pay/prescription	\$10 co-pay/prescription	\$20 co-pay applies to mail order.
More information about <u>prescription</u>	Non-preferred brand drugs	\$10 co-pay/prescription	\$10 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.

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Group ID: 00962347  
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# BlueShield of Northeastern NY: Traditional Blue 998

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

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: Indemnity

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<u>drug coverage</u> is available at <a href="http://www.bsneny.com">www.bsneny.com</a> .	Specialty drugs	See Limitations & Exceptions	See Limitations & Exceptions	Please contact your Pharmacy Benefits Manager for more detail.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% co-insurance	0% co-insurance	
	Physician/surgeon fees	0% co-insurance	0% co-insurance	
<b>If you need immediate medical attention</b>	Emergency room services	0% co-insurance	0% co-insurance	
	Emergency medical transportation	0% co-insurance	0% co-insurance	20% co-insurance for Ambulette, Air and Volunteer Ambulance services
	Urgent care	20% co-insurance	20% co-insurance	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% co-insurance	0% co-insurance	
	Physician/surgeon fee	0% co-insurance	0% co-insurance	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	20% co-insurance	20% co-insurance	
	Mental/Behavioral health inpatient services	0% co-insurance	0% co-insurance	
	Substance use disorder outpatient services	0% co-insurance	0% co-insurance	
	Substance use disorder inpatient services	0% co-insurance	0% co-insurance	
<b>If you are pregnant</b>	Prenatal and postnatal care	0% co-insurance	0% co-insurance	
	Delivery and all inpatient services	0% co-insurance	0% co-insurance	

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Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: Indemnity

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<b>If you need help recovering or have other special health needs</b>	Home health care	0% co-insurance	0% co-insurance	
	Rehabilitation services	0% co-insurance	0% co-insurance	
	Habilitation services	0% co-insurance	0% co-insurance	
	Skilled nursing care	\$0 co-pay/visit	\$0 co-pay/visit	
	Durable medical equipment	20% co-insurance	20% co-insurance	
	Hospice service	0% co-insurance	0% co-insurance	
<b>If your child needs dental or eye care</b>	Eye exam	See limitations and exceptions	See limitations and exceptions	Member cost share will vary. Refer to your Summary Plan Description for coverage details.
	Glasses	Not covered	Not covered	
	Dental check-up	See limitations and exceptions	See limitations and exceptions	Member cost share will vary. Refer to your Summary Plan Description for coverage details.

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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
- Cosmetic Surgery
- Custodial care
- Dental care (Adult)
- Hearing aids
- Long-term care
- 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.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the United States

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

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### Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$7,270**
- **Patient pays \$270**

#### Sample care costs:

Hospital charges (mother)	\$2,700
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Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$100
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$170
<b>Total</b>	<b>\$270</b>

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$1,930**
- **Patient pays \$3,470**

#### Sample care costs:

Prescriptions	\$2,900
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Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$100
Copays	\$0
Coinsurance	\$440
Limits or exclusions	\$2,930
<b>Total</b>	<b>\$3,470</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.
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- 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.

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### 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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Group ID: 00962347  
Class: 0002 20150105

# Medical and Prescription Drug Benefits

## POS 298 (0003)

Below is a brief outline of the Self Insured POS 298 plan available to full time employees of the City of Plattsburgh. You may obtain a more detailed Benefit Summary of this plan from Karen Rulfs @ First Niagara.

Services – POS 298 (0003)	In-Network	Out-of-Network
Deductible	None	\$250 / \$500
Coinsurance	None	20%
Out of Pocket Maximum	None	\$5,000 / \$10,000
Office Visit Copay	\$0 PCP / \$20 Specialist \$5 PCP / \$15 Specialist	Subject to Deductible & Coinsurance
Adult Routine Physical Exams	PCP copay	Subject to Deductible & Coinsurance
Mammography	Covered in full	Subject to Deductible & Coinsurance
Pap Smear	Covered in full	Subject to Deductible & Coinsurance
Routine GYN Exam	Specialist copay	Subject to Deductible & Coinsurance
Prostate Cancer Screening	No coverage	No coverage
In-Patient Hospital Benefits	Covered in full	Subject to Deductible & Coinsurance
Out-Patient Surgery	Specialist copay	Subject to Deductible & Coinsurance
Urgent Care – Has to be ER or Primary Care Physician (PCP)	PCP copay	Subject to Deductible & Coinsurance
Vision Benefit	Specialist copay	No coverage
Emergency Room	\$35 copay	\$35 copay
Diagnostic X-Rays	Covered in full	Subject to Deductible & Coinsurance
Diagnostic Laboratory and Pathology	Covered in full	Subject to Deductible & Coinsurance
<b>PROACT Prescription Drug</b> – Retail Pharmacy, 30 days <b>PROACT Prescription Drug</b> —Mail Order, 90 days <b>CanarX</b> —\$0 Copay, Mail Order, 90 days, BRAND NAME drugs only	\$5 Generic \$20 Preferred Brand \$40 Non Preferred Brand	No Coverage

### PAYROLL DEDUCTIONS (48 PAY PERIODS) FOR 2015

POS 298 (Class 0003)	Employee Only	Two Person	Family
<b>Self Insured</b>	<b>\$ 21.29</b>	<b>\$ 43.65</b>	<b>\$ 58.12</b>



**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.bsneny.com](http://www.bsneny.com) or by calling 1-888-840-6322.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	In-network providers: None Out-of-network providers: \$250 Individual/\$500 Family	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes. In-network providers: None Out-of-network providers: \$5,000 Individual/\$10,000 Family	The <b>out-of-pocket limit</b> 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	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
<b>Does this plan use a <u>network of providers</u>?</b>	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 <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-888-840-6322 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 1-888-840-6322 to request a copy.

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Class: 0003 20150105

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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 an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$0 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$5 Co-pay for Plan Option 3: \$10
	Specialist visit	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Other practitioner office visit	\$10 co-pay/visit for chiropractor, Not covered for acupuncture	20% co-insurance for chiropractor, Not covered for acupuncture	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Preventive care/screening/immunization	\$0 co-pay/visit	20% co-insurance	Refer to Summary Plan Description for covered preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 co-pay/visit	20% co-insurance	
	Imaging (CT/PET scans, MRIs)	\$0 co-pay/visit	20% co-insurance	
If you need drugs to treat your illness or condition  More information about <u>prescription</u>	Generic drugs	\$5 co-pay/prescription	\$5 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
	Preferred brand drugs	\$20 co-pay/prescription	\$20 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
	Non-preferred brand drugs	\$40 co-pay/prescription	\$40 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Group ID: 00962347  
Class: 0003 20150105

# BlueShield of Northeastern NY: Traditional Blue POS 298

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

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: POS

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
<u>drug coverage</u> is available at <a href="http://www.bsneny.com">www.bsneny.com</a> .	Specialty drugs	See Limitations & Exceptions	See Limitations & Exceptions	Please contact your Pharmacy Benefits Manager for more detail.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Physician/surgeon fees	\$0 co-pay/visit	20% co-insurance	
<b>If you need immediate medical attention</b>	Emergency room services	\$35 co-pay/visit	\$35 co-pay/visit	
	Emergency medical transportation	\$0 co-pay/visit	\$0 co-pay/visit	
	Urgent care	\$0 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$5 Co-pay for Plan Option 3: \$10
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$0 co-pay/visit	20% co-insurance	
	Physician/surgeon fee	\$0 co-pay/visit	20% co-insurance	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Mental/Behavioral health inpatient services	\$0 co-pay/visit	20% co-insurance	
	Substance use disorder outpatient services	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Substance use disorder inpatient services	\$0 co-pay/visit	20% co-insurance	
<b>If you are pregnant</b>	Prenatal and postnatal care	PCP co-pay	20% co-insurance	For participating providers, cost share applies only to initial visit to determine pregnancy
	Delivery and all inpatient services	\$0 co-pay/visit	20% co-insurance	

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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# BlueShield of Northeastern NY: Traditional Blue POS 298

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

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: POS

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
<b>If you need help recovering or have other special health needs</b>	Home health care	\$0 co-pay/visit	20% co-insurance	
	Rehabilitation services	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Habilitation services	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Skilled nursing care	\$0 co-pay/visit	20% co-insurance	
	Durable medical equipment	20% co-insurance	50% co-insurance	
	Hospice service	\$0 co-pay/visit	20% co-insurance	
<b>If your child needs dental or eye care</b>	Eye exam	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.
	Glasses	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.
	Dental check-up	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.

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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
- Cosmetic Surgery
- Custodial care
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- 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
- Infertility treatment
- Non-emergency care when traveling outside the United States
- Routine eye care (Adult)

**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.**

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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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 1-888-840-6322. 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: 1-888-840-6322.

## 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 1-888-840-6322.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-840-6322.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-840-6322.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-840-6322.

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

**Questions:** Call 1-888-840-6322 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 \$7,370**
- **Patient pays \$170**

#### 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	\$0
Coinsurance	\$0
Limits or exclusions	\$170
<b>Total</b>	<b>\$170</b>

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$2,120**
- **Patient pays \$3,280**

#### 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	\$100
Coinsurance	\$250
Limits or exclusions	\$2,930
<b>Total</b>	<b>\$3,280</b>

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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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.

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Class: 0003 20150105

# Medical and Prescription Drug Benefits

## POS 298 (0004)

Below is a brief outline of the Self Insured POS 298 plan available to full time employees of the City of Plattsburgh. You may obtain a more detailed Benefit Summary of this plan from Karen Rulfs @ First Niagara.

Services – POS 298 (0004)	In-Network	Out-of-Network
Deductible	None	\$500 / \$1,000
Coinsurance	None	25%
Out of Pocket Maximum	None	Unlimited
Office Visit Copay	\$20 copay	Subject to Deductible & Coinsurance
Adult Routine Physical Exams	\$20 copay	Subject to Deductible & Coinsurance
Mammography	Covered in full	Subject to Deductible & Coinsurance
Pap Smear	Covered in full	Subject to Deductible & Coinsurance
Routine GYN Exam	\$20 copay	Subject to Deductible & Coinsurance
Prostate Cancer Screening	No coverage	No coverage
In-Patient Hospital Benefits	\$250 copay	Subject to Deductible & Coinsurance
Out-Patient Surgery	\$75 copay	Subject to Deductible & Coinsurance
Urgent Care – Has to be ER or Primary Care Physician (PCP)	PCP copay	Subject to Deductible & Coinsurance
Vision Benefit	\$20 copay	No coverage
Emergency Room	\$50 copay	\$50 copay
Diagnostic X-Rays	Covered in full	Subject to Deductible & Coinsurance
Diagnostic Laboratory and Pathology	Covered in full	Subject to Deductible & Coinsurance
<b>PROACT Prescription Drug</b> – Retail Pharmacy 30 days <b>PROACT Prescription Drug</b> —Mail Order, 90 days <b>CanRX</b> —\$0 Copay, Mail Order, 90 days, BRAND NAME drugs only	\$10 Generic \$20 Preferred Brand \$40 Non Preferred Brand	No Coverage

### PAYROLL DEDUCTIONS (48 PAY PERIODS) FOR 2015

POS 298 (Class 0003)	Employee Only	Two Person	Family
<b>Self Insured</b>	<b>\$ 18.54</b>	<b>\$ 38.01</b>	<b>\$ 49.12</b>



**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.bsneny.com](http://www.bsneny.com) or by calling 1-888-840-6322.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	In-network providers: None Out-of-network providers: \$500 Individual/\$1,000 Family	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	No	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	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
<b>Does this plan use a network of providers?</b>	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 <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Class: 0004 20150105

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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 an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay/visit	25% co-insurance	
	Specialist visit	\$20 co-pay/visit	25% co-insurance	
	Other practitioner office visit	\$10 co-pay/visit for chiropractor, Not covered for acupuncture	25% co-insurance for chiropractor, Not covered for acupuncture	
	Preventive care/screening/immunization	\$0 co-pay/visit	25% co-insurance	Refer to Summary Plan Description for covered preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 co-pay/visit	25% co-insurance	
	Imaging (CT/PET scans, MRIs)	\$0 co-pay/visit	25% co-insurance	
If you need drugs to treat your illness or condition	Generic drugs	\$10 co-pay/prescription	\$10 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
	Preferred brand drugs	\$20 co-pay/prescription	\$20 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
More information about <u>prescription</u>	Non-preferred brand drugs	\$40 co-pay/prescription	\$40 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Group ID: 00962347  
Class: 0004 20150105

# BlueShield of Northeastern NY: Traditional Blue POS 298

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

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: POS

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
<u>drug coverage</u> is available at <a href="http://www.bsneny.com">www.bsneny.com</a> .	Specialty drugs	See Limitations & Exceptions	See Limitations & Exceptions	Please contact your Pharmacy Benefits Manager for more detail.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$75 co-pay/visit	25% co-insurance	
	Physician/surgeon fees	\$0 co-pay/visit	25% co-insurance	
<b>If you need immediate medical attention</b>	Emergency room services	\$50 co-pay/visit	\$50 co-pay/visit	
	Emergency medical transportation	\$0 co-pay/visit	\$0 co-pay/visit	
	Urgent care	\$20 co-pay/visit	25% co-insurance	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 co-pay/visit	25% co-insurance	
	Physician/surgeon fee	\$0 co-pay/visit	25% co-insurance	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$20 co-pay/visit	25% co-insurance	
	Mental/Behavioral health inpatient services	\$250 co-pay/visit	25% co-insurance	
	Substance use disorder outpatient services	\$20 co-pay/visit	25% co-insurance	
	Substance use disorder inpatient services	\$250 co-pay/visit	25% co-insurance	
<b>If you are pregnant</b>	Prenatal and postnatal care	\$20 co-pay/visit	25% co-insurance	For participating providers, cost share applies only to initial visit to determine pregnancy
	Delivery and all inpatient services	\$0 co-pay/visit	25% co-insurance	

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Group ID: 00962347  
Class: 0004 20150105

# BlueShield of Northeastern NY: Traditional Blue POS 298

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

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: POS

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
<b>If you need help recovering or have other special health needs</b>	Home health care	\$0 co-pay/visit	25% co-insurance	
	Rehabilitation services	\$20 co-pay/visit	25% co-insurance	
	Habilitation services	\$20 co-pay/visit	25% co-insurance	
	Skilled nursing care	\$250 co-pay/visit	25% co-insurance	
	Durable medical equipment	20% co-insurance	50% co-insurance	
	Hospice service	\$0 co-pay/visit	25% co-insurance	
<b>If your child needs dental or eye care</b>	Eye exam	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.
	Glasses	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.
	Dental check-up	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.

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Group ID: 00962347  
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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
- Cosmetic Surgery
- Custodial care
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- 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
- Infertility treatment
- Non-emergency care when traveling outside the United States
- Routine eye care (Adult)

**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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Group ID: 00962347  
Class: 0004 20150105

### 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 1-888-840-6322. 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: 1-888-840-6322.

### 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:

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-888-840-6322.

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

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Group ID: 00962347  
Class: 0004 20150105

## 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 \$7,120**
- **Patient pays \$420**

#### 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	\$250
Coinsurance	\$0
Limits or exclusions	\$170
<b>Total</b>	<b>\$420</b>

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$2,020**
- **Patient pays \$3,380**

#### 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	\$250
Limits or exclusions	\$2,930
<b>Total</b>	<b>\$3,380</b>

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Group ID: 00962347  
 Class: 0004 20150105

## 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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Group ID: 00962347  
Class: 0004 20150105

# Medical and Prescription Drug Benefits

## POS 298 (0005 & 0006)

Below is a brief outline of the Self Insured POS 298 plan available to full time employees of the City of Plattsburgh. You may obtain a more detailed Benefit Summary of this plan from Karen Rulfs @ First Niagara.

Services – POS 298 (0005 & 0006)	In-Network	Out-of-Network
Deductible	None	\$250 / \$500
Coinsurance	None	20%
Out of Pocket Maximum	None	\$5,000 / \$10,000
Office Visit Copay	\$0 PCP / \$20 Specialist \$5 PCP / \$15 Specialist	Subject to Deductible & Coinsurance
Adult Routine Physical Exams	PCP copay	Subject to Deductible & Coinsurance
Mammography	Covered in full	Subject to Deductible & Coinsurance
Pap Smear	Covered in full	Subject to Deductible & Coinsurance
Routine GYN Exam	Specialist copay	Subject to Deductible & Coinsurance
Prostate Cancer Screening	No coverage	No coverage
In-Patient Hospital Benefits	Covered in full	Subject to Deductible & Coinsurance
Out-Patient Surgery	Specialist copay	Subject to Deductible & Coinsurance
Urgent Care – Has to be ER or Primary Care Physician (PCP)	PCP copay	Subject to Deductible & Coinsurance
Vision Benefit	Specialist copay	No coverage
Emergency Room	\$35 copay	\$35 copay
Diagnostic X-Rays	Covered in full	Subject to Deductible & Coinsurance
Diagnostic Laboratory and Pathology	Covered in full	Subject to Deductible & Coinsurance
<b>PROACT Prescription Drug</b> – Retail Pharmacy ,30 days <b>PROACT Prescription Drug</b> —Mail Order, 90 days <b>CanarX</b> —\$0 Copay, Mail Order, 90 days, BRAND NAME drugs only	\$5 Generic \$10 Preferred Brand \$25 Non Preferred Brand	No Coverage

### PAYROLL DEDUCTIONS (48 PAY PERIODS) FOR 2015

POS 298 (Class 0003)	Employee Only	Two Person	Family
<b>Self Insured</b>	<b>\$ 22.17</b>	<b>\$ 45.46</b>	<b>\$ 60.54</b>



**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.bsneny.com](http://www.bsneny.com) or by calling 1-888-840-6322.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	In-network providers: None Out-of-network providers: \$250 Individual/\$500 Family	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes. In-network providers: None Out-of-network providers: \$5,000 Individual/\$10,000 Family	The <b>out-of-pocket limit</b> 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	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
<b>Does this plan use a <u>network of providers</u>?</b>	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 <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .

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Group ID: 00962347  
Class: 0005 20150105

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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 an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$0 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$5 Co-pay for Plan Option 3: \$10
	Specialist visit	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Other practitioner office visit	\$10 co-pay/visit for chiropractor, Not Covered for acupuncture	20% co-insurance for chiropractor, Not Covered for acupuncture	
	Preventive care/screening/immunization	\$0 co-pay/visit	20% co-insurance	Refer to Summary Plan Description for covered preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 co-pay/visit	20% co-insurance	
	Imaging (CT/PET scans, MRIs)	\$0 co-pay/visit	20% co-insurance	
If you need drugs to treat your illness or condition	Generic drugs	\$5 co-pay/prescription	\$5 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
	Preferred brand drugs	\$10 co-pay/prescription	\$10 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
	Non-preferred brand drugs	\$25 co-pay/prescription	\$25 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
More information about <u>prescription</u>				

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Group ID: 00962347  
Class: 0005 20150105

# BlueShield of Northeastern NY: Traditional Blue POS 298

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

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: POS

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
<u>drug coverage</u> is available at <a href="http://www.bsneny.com">www.bsneny.com</a> .	Specialty drugs	See Limitations & Exceptions	See Limitations & Exceptions	Specialty drugs could be generic, preferred brand, or non-preferred brand. Please contact your Pharmacy Benefits Manager for more detail.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Physician/surgeon fees	\$0 co-pay/visit	20% co-insurance	
<b>If you need immediate medical attention</b>	Emergency room services	\$35 co-pay/visit	\$35 co-pay/visit	
	Emergency medical transportation	\$0 co-pay/visit	\$0 co-pay/visit	
	Urgent care	\$0 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$5 Co-pay for Plan Option 3: \$10
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$0 co-pay/visit	20% co-insurance	
	Physician/surgeon fee	\$0 co-pay/visit	20% co-insurance	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Mental/Behavioral health inpatient services	\$0 co-pay/visit	20% co-insurance	
	Substance use disorder outpatient services	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Substance use disorder inpatient services	\$0 co-pay/visit	20% co-insurance	
<b>If you are pregnant</b>	Prenatal and postnatal care	PCP co-pay	20% co-insurance	For participating providers, cost share applies only to initial visit to determine pregnancy
	Delivery and all inpatient services	\$0 co-pay/visit	20% co-insurance	

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Coverage for: Single/Family | Plan Type: POS

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
<b>If you need help recovering or have other special health needs</b>	Home health care	\$0 co-pay/visit	20% co-insurance	
	Rehabilitation services	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Habilitation services	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Skilled nursing care	\$0 co-pay/visit	20% co-insurance	
	Durable medical equipment	20% co-insurance	50% co-insurance	
	Hospice service	\$0 co-pay/visit	20% co-insurance	
<b>If your child needs dental or eye care</b>	Eye exam	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.
	Glasses	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.
	Dental check-up	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.

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#### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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- Cosmetic Surgery
- Custodial care
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- 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
- Infertility treatment
- Non-emergency care when traveling outside the United States
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For more information on your rights to continue coverage, contact the plan at 1-888-840-6322. 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).

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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: 1-888-840-6322.

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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.**

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Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-840-6322.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-840-6322.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-840-6322.

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

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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.



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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 \$7,370**
- **Patient pays \$170**

#### 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	\$0
Coinsurance	\$0
Limits or exclusions	\$170
<b>Total</b>	<b>\$170</b>

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$2,220**
- **Patient pays \$3,180**

#### 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	\$100
Coinsurance	\$250
Limits or exclusions	\$2,930
<b>Total</b>	<b>\$3,180</b>

**Questions:** Call 1-888-840-6322 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 1-888-840-6322 to request a copy.

Group ID: 00962347  
 Class: 0005 20150105

## 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.

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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**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.bsneny.com](http://www.bsneny.com) or by calling 1-888-840-6322.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	In-network providers: None Out-of-network providers: \$250 Individual/\$500 Family	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes. In-network providers: None Out-of-network providers: \$5,000 Individual/\$10,000 Family	The <b>out-of-pocket limit</b> 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	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
<b>Does this plan use a <u>network of providers</u>?</b>	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 <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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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 an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$0 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$5 Co-pay for Plan Option 3: \$10
	Specialist visit	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Other practitioner office visit	\$10 co-pay/visit for chiropractor, Not covered for acupuncture	20% co-insurance for chiropractor, Not covered for acupuncture	
	Preventive care/screening/immunization	\$0 co-pay/visit	20% co-insurance	Refer to Summary Plan Description for covered preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 co-pay/visit	20% co-insurance	
	Imaging (CT/PET scans, MRIs)	\$0 co-pay/visit	20% co-insurance	
If you need drugs to treat your illness or condition	Generic drugs	\$5 co-pay/prescription	\$5 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
	Preferred brand drugs	\$10 co-pay/prescription	\$10 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
	Non-preferred brand drugs	\$25 co-pay/prescription	\$25 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
More information about <u>prescription</u>				

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Class: 0006 20150105

# BlueShield of Northeastern NY: Traditional Blue POS 298

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

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: POS

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
<u>drug coverage</u> is available at <a href="http://www.bsneny.com">www.bsneny.com</a> .	Specialty drugs	See Limitations & Exceptions	See Limitations & Exceptions	Please contact your Pharmacy Benefits Manager for more detail.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Physician/surgeon fees	\$0 co-pay/visit	20% co-insurance	
<b>If you need immediate medical attention</b>	Emergency room services	\$35 co-pay/visit	\$35 co-pay/visit	
	Emergency medical transportation	\$0 co-pay/visit	\$0 co-pay/visit	
	Urgent care	\$0 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$5 Co-pay for Plan Option 3: \$10
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$0 co-pay/visit	20% co-insurance	
	Physician/surgeon fee	\$0 co-pay/visit	20% co-insurance	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Mental/Behavioral health inpatient services	\$0 co-pay/visit	20% co-insurance	
	Substance use disorder outpatient services	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Substance use disorder inpatient services	\$0 co-pay/visit	20% co-insurance	
<b>If you are pregnant</b>	Prenatal and postnatal care	PCP co-pay	20% co-insurance	For participating providers, cost share applies only to initial visit to determine pregnancy
	Delivery and all inpatient services	\$0 co-pay/visit	20% co-insurance	

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Group ID: 00962347  
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# BlueShield of Northeastern NY: Traditional Blue POS 298

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

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: POS

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
<b>If you need help recovering or have other special health needs</b>	Home health care	\$0 co-pay/visit	20% co-insurance	
	Rehabilitation services	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Habilitation services	\$20 co-pay/visit	20% co-insurance	Co-pay for Plan Option 2: \$15 Co-pay for Plan Option 3: \$10
	Skilled nursing care	\$0 co-pay/visit	20% co-insurance	
	Durable medical equipment	20% co-insurance	50% co-insurance	
	Hospice service	\$0 co-pay/visit	20% co-insurance	
<b>If your child needs dental or eye care</b>	Eye exam	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.
	Glasses	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.
	Dental check-up	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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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
- Cosmetic Surgery
- Custodial care
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- 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
- Infertility treatment
- Non-emergency care when traveling outside the United States
- Routine eye care (Adult)

**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.**

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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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 1-888-840-6322. 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: 1-888-840-6322.

## 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 1-888-840-6322.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-840-6322.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-840-6322.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-840-6322.

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

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Group ID: 00962347  
Class: 0006 20150105

## 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 \$7,370**
- **Patient pays \$170**

#### 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	\$0
Coinsurance	\$0
Limits or exclusions	\$170
<b>Total</b>	<b>\$170</b>

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$2,220**
- **Patient pays \$3,180**

#### 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	\$0
Coinsurance	\$250
Limits or exclusions	\$2,930
<b>Total</b>	<b>\$3,180</b>

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Group ID: 00962347  
 Class: 0006 20150105

## 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.

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Class: 0006 20150105

# Medical and Prescription Drug Benefits

## POS 298 (0007)

Below is a brief outline of the Self Insured POS 298 plan available to full time employees of the City of Plattsburgh. You may obtain a more detailed Benefit Summary of this plan from Karen Rulfs @ First Niagara.

Services – POS 298 (0007)	In-Network	Out-of-Network
Deductible	None	\$500 / \$1,000
Coinsurance	None	25%
Out of Pocket Maximum	None	Unlimited
Office Visit Copay	\$20 copay	Subject to Deductible & Coinsurance
Adult Routine Physical Exams	\$20 copay	Subject to Deductible & Coinsurance
Mammography	Covered in full	Subject to Deductible & Coinsurance
Pap Smear	Covered in full	Subject to Deductible & Coinsurance
Routine GYN Exam	\$20 copay	Subject to Deductible & Coinsurance
Prostate Cancer Screening	No coverage	No coverage
In-Patient Hospital Benefits	\$250 copay	Subject to Deductible & Coinsurance
Out-Patient Surgery	\$75 copay	Subject to Deductible & Coinsurance
Urgent Care – Has to be ER or Primary Care Physician (PCP)	\$20 copay	Subject to Deductible & Coinsurance
Vision Benefit	\$20 copay	No coverage
Emergency Room	\$50 copay	\$50 copay
Diagnostic X-Rays	Covered in full	Subject to Deductible & Coinsurance
Diagnostic Laboratory and Pathology	Covered in full	Subject to Deductible & Coinsurance
<b>PROACT Prescription Drug</b> – Retail Pharmacy 30 days <b>PROACT Prescription Drug</b> —Mail Order, 90 days <b>CanRX</b> —\$0 Copay, Mail Order, 90 days, BRAND NAME drugs only	\$5 Generic \$10 Preferred Brand \$25 Non Preferred Brand	No Coverage

### PAYROLL DEDUCTIONS (48 PAY PERIODS) FOR 2015

POS 298 (Class 0003)	Employee Only	Two Person	Family
<b>Self Insured</b>	<b>\$ 19.70</b>	<b>\$ 40.38</b>	<b>\$ 52.16</b>



**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.bsneny.com](http://www.bsneny.com) or by calling 1-888-840-6322.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	In-network providers: None Out-of-network providers: \$500 Individual/\$1,000 Family	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	No	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	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
<b>Does this plan use a network of providers?</b>	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 <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Class: 0007 20150105

- 
- **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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay/visit	25% co-insurance	
	Specialist visit	\$20 co-pay/visit	25% co-insurance	
	Other practitioner office visit	\$10 co-pay/visit for chiropractor, Not covered for acupuncture	25% co-insurance for chiropractor, Not Covered for acupuncture	
	Preventive care/screening/immunization	\$0 co-pay/visit	25% co-insurance	Refer to Summary Plan Description for covered preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 co-pay/visit	25% co-insurance	
	Imaging (CT/PET scans, MRIs)	\$0 co-pay/visit	25% co-insurance	
If you need drugs to treat your illness or condition	Generic drugs	\$5 co-pay/prescription	\$5 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
	Preferred brand drugs	\$10 co-pay/prescription	\$10 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.
More information about <u>prescription</u>	Non-preferred brand drugs	\$25 co-pay/prescription	\$25 co-pay/prescription	Please contact your Pharmacy Benefits Manager for more detail.

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Group ID: 00962347  
Class: 0007 20150105

# BlueShield of Northeastern NY: Traditional Blue POS 298

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

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: POS

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
<u>drug coverage</u> is available at <a href="http://www.bsneny.com">www.bsneny.com</a> .	Specialty drugs	See Limitations & Exceptions	See Limitations & Exceptions	Please contact your Pharmacy Benefits Manager for more detail.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$75 co-pay/visit	25% co-insurance	
	Physician/surgeon fees	\$0 co-pay/visit	25% co-insurance	
<b>If you need immediate medical attention</b>	Emergency room services	\$50 co-pay/visit	\$50 co-pay/visit	
	Emergency medical transportation	\$0 co-pay/visit	\$0 co-pay/visit	
	Urgent care	\$20 co-pay/visit	25% co-insurance	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 co-pay/visit	25% co-insurance	
	Physician/surgeon fee	\$0 co-pay/visit	25% co-insurance	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$20 co-pay/visit	25% co-insurance	
	Mental/Behavioral health inpatient services	\$250 co-pay/visit	25% co-insurance	
	Substance use disorder outpatient services	\$20 co-pay/visit	25% co-insurance	
	Substance use disorder inpatient services	\$250 co-pay/visit	25% co-insurance	
<b>If you are pregnant</b>	Prenatal and postnatal care	\$20 co-pay/visit	25% co-insurance	For participating providers, cost share applies only to initial visit to determine pregnancy
	Delivery and all inpatient services	\$0 co-pay/visit	25% co-insurance	

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# BlueShield of Northeastern NY: Traditional Blue POS 298

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

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Single/Family | Plan Type: POS

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
<b>If you need help recovering or have other special health needs</b>	Home health care	\$0 co-pay/visit	25% co-insurance	
	Rehabilitation services	\$20 co-pay/visit	25% co-insurance	
	Habilitation services	\$20 co-pay/visit	25% co-insurance	
	Skilled nursing care	\$250 co-pay/visit	25% co-insurance	
	Durable medical equipment	20% co-insurance	50% co-insurance	
	Hospice service	\$0 co-pay/visit	25% co-insurance	
<b>If your child needs dental or eye care</b>	Eye exam	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.
	Glasses	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details..
	Dental check-up	See limitations and exceptions	Not covered	Member cost share will vary. Refer to your Summary Plan Description for coverage details.

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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
- Cosmetic Surgery
- Custodial care
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- 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
- Infertility treatment
- Non-emergency care when traveling outside the United States
- Routine eye care (Adult)

**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.**

**Questions:** Call 1-888-840-6322 or visit us at [www.bsneny.com](http://www.bsneny.com).

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Group ID: 00962347  
Class: 0007 20150105

## 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 1-888-840-6322. 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: 1-888-840-6322.

## 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 1-888-840-6322.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-840-6322.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-840-6322.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-840-6322.

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

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Group ID: 00962347  
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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 \$7,370**
- **Patient pays \$170**

#### 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	\$0
Coinsurance	\$0
Limits or exclusions	\$170
<b>Total</b>	<b>\$170</b>

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$2,120**
- **Patient pays \$3,280**

#### 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	\$100
Coinsurance	\$250
Limits or exclusions	\$2,930
<b>Total</b>	<b>\$3,280</b>

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Group ID: 00962347  
 Class: 0007 20150105

## 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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Group ID: 00962347  
Class: 0007 20150105

# ONLINE TOOLS for BLUESHIELD

To Manage Your Health  
[www.bsny.com](http://www.bsny.com)

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## What Can You Do with Online Service?

Online services is your secure resource for personalized health care information and services.\*

- Order a new member ID card
- Review your claims history
- Reorder prescription drugs
- Talk to a customer service representative with online chat
- Access complimentary online health and wellness tools
- Estimate the cost of care
- Research treatment options and local hospitals
- View your Explanation of Benefits
- Locate a participating provider
- Select a Primary Care Physician

## Before You Get Started...

	<b>BlueCross BlueShield</b>	Government-Wide Service Benefits Plan	PPO
<b>Federal Employee Program</b>		<a href="http://www.fepblue.org">www.fepblue.org</a>	
Member Name	IM Sample		
Member ID	R9999999		
Enrollment Code	104	RollN	610239
Effective Date	01/01/2008	RxPCN	FPRX
		RxGrp	65006500

*Have your BlueShield member ID card handy.*

\*Availability of services determined by your coverage plan.

## Getting Started is EASY!

1. Log on to [www.bsny.com](http://www.bsny.com)
2. Go to "Manage your Account" in the top right corner and select "Member" from the drop down menu.
3. Click the "Register Now!" link.
  - Enter information from your ID card
  - Enter your personal information
  - Choose a password
4. Once your registration is complete, you can sign in immediately and start using the online tools.

The personal information that you enter is secure and protected. When you set up an online account, you will be able to view information for yourself. If you are the subscriber, you will be able to view information for dependents under the age of 18.



# NOTIFICATIONS

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- **ANNUAL NOTICES:**

- Special Enrollment Rights

- Women's Health and Cancer Rights Act of 1998

- Newborns and Mothers Health Protection Act

- Right of Nursing Mothers to Express Breast Milk

- Blood Donation

- Summary of Material Modifications

- **HIPPA PRIVACY PRACTICES**

- **WOMEN'S HEALTH AND CANCER RIGHTS' ACT OF 1998**

- **YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE**

- **GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS**

- **PREMIUM ASSISTANCE UNDER MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)**

- **HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE**

# Annual Notices

## **Special Enrollment Rights**

If you are declining enrollment in the medical plan for yourself or for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your coverage ends and provide supporting documentation. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the medical plan, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

## **Women's Health and Cancer Rights Act of 1998**

This medical plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymph edema.

## **Newborns and Mothers Health Protection Act**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## **Right of Nursing Mothers to Express Breast Milk**

An employer shall provide reasonable unpaid break time or permit an employee to use paid break time or meal time each day to allow an employee to express breast milk for her nursing child for up to three years following child birth. The employer shall make reasonable efforts to provide a room or other location, in close proximity to the work area, where an employee can express milk in privacy. No employer shall discriminate in any way against an employee who chooses to express breast milk in the workplace.

An employee wishing to avail herself of this benefit is required to give her employer advance notice, preferably prior to the employee's return to work following the birth of her child, to allow the employer an opportunity to establish a location and to schedule leave time among multiple employees, if needed.

The New York Commissioner of Labor announced that "reasonable unpaid break time" is "sufficient time to allow the employee to express breast milk," and shall generally be no less than twenty (20) minutes, and generally no more than thirty (30) minutes depending on the proximity of the designated location for expressing breast milk. In most situations, employers are required to provide unpaid break time for the expressing of breast milk at least once every three (3) hours if requested by the employee. At the employee's option, the employer must allow her to work before or after her normal shift (during the employer's normal work hours) to make up for the unpaid break time.

## **Blood Donation**

Section 202-j of the Labor Law mandates that employers provide leave time to employees for the purpose of donating blood. Leave taken by employees for donation alternatives shall be paid leave (i.e. blood drive at the employee's place of employment). Employees taking leave for off-premises blood donation shall be permitted at least one leave period per calendar year of three hours duration during the employee's regular work schedule. Leave granted to employees for off-premises blood donation is not required to be paid leave.

## **Summary of Material Modifications**

This Summary of Material Modifications describes certain changes that will become effective to the City of Plattsburgh benefit plans for the plan years. If there is a conflict between the information outlines in this material and the Plan's documents, the Plan's documents will govern. Please note that Plans may not cover certain services and procedures you wish to have performed. While these services will not be paid for by the applicable Plan, you should always determine the care that is best for you.



# HIPAA Privacy Practices

## Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (ie., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") if Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Participant's PHI, and inform him/her about:

1. The Plan's Disclosures and uses of PHI;
2. The Plan Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Plan Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

## How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclose is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

## Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
  - (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
    - (i) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    - (b) In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination) if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

## Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

## Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.



# HIPAA Privacy Practices

## Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

## Other Disclosures and Uses of PHI: Permissible Uses and Disclosures of PHI

- 1. Treatment, Payment and Health Care Operations:** The Plan has the right to use and disclose a Plan Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
- 2. Business Associates:** The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.
- 3. Other Covered Entities:** The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

## Other Permissible Uses and Disclosures of PHI

- 1. Required by Law:** The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.
- 2. Public Health and Safety:** The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
  - (a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse, neglect or domestic violence;
  - (b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
  - (c) locate and notify persons of recalls of products they may be using; and
  - (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.
- 3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence.** In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.
- 4. Health Oversight Activities:** The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.
- 5. Lawsuits and Disputes:** The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.
- 6. Law Enforcement:** The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.
- 7. Decedents:** The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The Plan may also disclose, as authorized by law, PHI to organizations that handle organ, eye, or tissue donation and transplantation.
- 8. Research:** The Plan may use or disclose PHI for research, subject to certain limited conditions.
- 9. To Avert a Serious Threat to Health or Safety:** The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
- 10. Workers' Compensation:** The Plan may disclose PHI when authorized by and to the Extent necessary to comply with workers' compensation or other similar programs established by law.
- 11. Inmates:** The Plan may disclose PHI when to the correctional institution or law enforcement official for: the institution to provide health care to the Plan Participant; the Plan Participant's health and safety and the health and safety of others; or the safety and security of the correctional institution.
- 12. Military and National Security:** The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.
- 13. Emergency Situations:** The Plan may disclose PHI in an emergency situation, or if the Plan Participant is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. The Plan will use professional judgment and experience to determine if the disclosure is in the Plan Participant's best interest. If the disclosure is in the Plan Participant's best interest, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the Plan Participant's care.
- 14. Fundraising Activities:** The Plan may disclose PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does not contact the Plan Participant for fundraising activities, the Plan will give the Plan Participant the opportunity to opt-out, or stop, receiving such communications in the future.
- 15. Group Health Plan Disclosures:** The Plan may disclose PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Plan Participant. The Plan can disclose PHI to that entity if that entity has contracted with the Plan to administer the Plan Participant's health care program on its behalf.
- 16. Underwriting Purposes:** The Plan may disclose PHI for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does not disclose the Plan Participant's PHI for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI that is genetic information.

## Uses and Disclosures of PHI that Require Authorization

- 1. Sale of PHI:** The Plan will request written authorization before it makes any disclosure that is deemed a sale of PHI, meaning the Plan is receiving compensation for disclosing the PHI in that manner.
- 2. Marketing:** The Plan will request written authorization to use or disclose PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Plan Participant or when the Plan provides promotional gifts of nominal value.
- 3. Psychotherapy Notes:** The Plan will request written authorization to use or disclose any of the Plan Participant's psychotherapy notes that may be on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of PHI that are not described above will be made only with written authorization. If the Plan Participant provides the Plan with such authorization, it may be revoked in writing and the revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that the Plan already used or disclosed, relying on the authorization.



# HIPAA Privacy Practices

## Required Disclosures of PHI

- Disclosures to Plan Participants:** The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.  
The Plan may elect not to treat the person as the Plan Participant's personal representative if it has a reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.
- Disclosures to the Secretary of the U.S. Department of Health and Human Services:** The Plan is required to disclose the Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.
- Business Associates:** The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.
- Other Covered Entities:** The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

## Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

## Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

- Request Restrictions:** The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.
- Right to Receive Confidential Communication:** The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.
- Copy of this Notice:** The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.
- Accounting of Disclosures:** The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include:
  - the date of the disclosure;
  - the name of the entity or person who received the PHI and, if known, the address of such entity or person;
  - a description of the PHI disclosed;
  - a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.
- Access:** The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.
- Amendment:** The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Plan Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

## Questions or Complaints

If the Plan Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request. The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

## Contact Information, Privacy Compliance Coordinator:

Ann Giard-Chase, PHR  
**Human Resources, City of Plattsburgh**  
 41 City hall Place  
 Plattsburgh, New York 12901  
 Phone: 518-536-7527  
 Fax: 518-536-7528  
 E-mail: chasea@cityofplattsburgh-ny.gov



**WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998****Annual Notice**

Dear Plan Participant:

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998 (hereafter referred to as the "Act"). The Act also contained a requirement that all participants of group health plan be notified annually about the benefits required to be provided under the provisions of the Act. This Notice therefore serves to provide you with a summary of the major provisions of the Act, and also provides you with the annual notice as required by law.

Our Plan will continue to provide benefits for mastectomies where medically appropriate and subject to the terms and conditions described within your Plan. As specified and required under the Act, any Participant of our group health plan who elects breast reconstruction in connection with a mastectomy, will also be entitled to coverage for the following additional benefits:

- Reconstruction on the breast on which a mastectomy was performed; and
- Surgery and reconstructive surgery on the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

All Benefits for the above types of care or treatment will be provided in the same manner as any other surgical procedure under the Plan, and will be provided in the manner determined by the attending physician and the patient (experimental procedures, as defined by the Group Health Plan, will not be considered).

Please note that the above benefits will be available to all participants from the first date that the participant is otherwise eligible for coverage under the Group Health Plan.

Please keep this notice in a safe place with your other documentation concerning the Plan. If you have any questions about the benefits provided under the Plan or as mandated under the Act, please contact Karen Rulfs, City of Plattsburgh's Benefit Office, #518-324-5335.

Sincerely,

*Ann Giard-Chase*

Ann Giard-Chase, PHR  
Human Resource Director  
City of Plattsburgh



# Important Notice from City of Plattsburgh About Your Prescription Drug Coverage and Medicare

**Please read this notice carefully and keep it where you can find it.** This notice has information about your current prescription drug coverage with the City of Plattsburgh and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

## **There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:**

- 1) Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- 2) The **City of Plattsburgh** has determined that the prescription drug coverage offered by **ProAct Pharmacy Services, Inc.** is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is **Creditable Coverage**, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### **When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a

two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

### **What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

- If you decide to join a Medicare drug plan, your current **City of Plattsburgh** coverage will not be affected.
- See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.
- If you do decide to join a Medicare drug plan and drop your current **City of Plattsburgh** coverage, be aware that you and your dependents will not be able to get this coverage back.

### **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with the City of Plattsburgh and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least

1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

### **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **the City of Plattsburgh** changes. You also may request a copy of this notice at any time. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

### **For more information about Medicare prescription drug coverage:**

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**



# General Notice Of COBRA Continuation Coverage Rights

## Introduction

You are receiving this notice because you have recently gained coverage under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

## What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

*If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:*

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

*If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:*

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

*Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:*

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

## When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events: the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

## You Must Give Notice of Some Qualifying Events

**For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.**

**You must provide this notice to: HR Department – Ann Giard- Chase 518-536-7527**



# General Notice Of COBRA Continuation Coverage Rights

## How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

### *Disability Extension of 18-month period of COBRA continuation coverage*

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

### *Second qualifying event Extension of 18-month period of continuation coverage*

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

## If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

## Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## Plan Contact Information

Ann Giard-Chase, PHR  
City of Plattsburgh Human Resources  
41 City Hall Place, Plattsburgh, NY 12901  
518-536-7527  
[chasea@cityofplattsburgh-ny.gov](mailto:chasea@cityofplattsburgh-ny.gov)

Karen Rulfs  
First Niagara Benefits  
186 U.S. Oval, Plattsburgh, NY 12903 (check this)  
518-324-5335  
[Karen.Rulfs@fnrm.com](mailto:Karen.Rulfs@fnrm.com)



## Premium Assistance Under Medicaid and Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272).

**To see if you are eligible for assistance paying your employer health plan premiums, check the list of states on pages 29 and 30 of this Guide. The list is current as of July 31, 2014. Contact your state for more information on eligibility.**

**To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either::**

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext.. 61565



**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. Contact your State for more information on eligibility –**

<b>ALABAMA – Medicaid</b>	<b>ALASKA – Medicaid</b>
Website: <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a> Phone: 1-855-692-5447	Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a> Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529
<b>ARIZONA – CHIP</b>	<b>COLORADO – Medicaid</b>
Website: <a href="http://www.azahcccs.gov/applicants">http://www.azahcccs.gov/applicants</a> Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Medicaid Website: <a href="http://www.colorado.gov/">http://www.colorado.gov/</a> Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
<b>FLORIDA – Medicaid</b>	<b>IDAHO – Medicaid</b>
Website: <a href="https://www.flmedicaidtplrecovery.com/">https://www.flmedicaidtplrecovery.com/</a> Phone: 1-877-357-3268	Medicaid Website: <a href="http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx">http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx</a> Medicaid Phone: 1-800-926-2588
<b>GEORGIA – Medicaid</b>	<b>INDIANA – Medicaid</b>
Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a> - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150	Website: <a href="http://www.in.gov/fssa">http://www.in.gov/fssa</a> Phone: 1-800-889-9949
<b>IOWA – Medicaid</b>	<b>MONTANA – Medicaid</b>
Website: <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a> Phone: 1-888-346-9562	Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a> Phone: 1-800-694-3084
<b>NEBRASKA – Medicaid</b>	<b>NEVADA – Medicaid</b>
Website: <a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a> Phone: 1-800-383-4278	Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a> Medicaid Phone: 1-800-992-0900
<b>KANSAS – Medicaid</b>	<b>NEW HAMPSHIRE – Medicaid</b>
Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a> Phone: 1-800-792-4884	Website: <a href="http://www.dhhs.nh.gov/oi/documents/hippapp.pdf">http://www.dhhs.nh.gov/oi/documents/hippapp.pdf</a> Phone: 603-271-5218
<b>KENTUCKY – Medicaid</b>	<b>LOUISIANA – Medicaid</b>
Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a> Phone: 1-800-635-2570	Website: <a href="http://www.lahipp.dhh.louisiana.gov">http://www.lahipp.dhh.louisiana.gov</a> Phone: 1-888-695-2447
<b>MAINE – Medicaid</b>	<b>NEW JERSEY – Medicaid and CHIP</b>
Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">http://www.maine.gov/dhhs/ofi/public-assistance/index.html</a> Phone: 1-800-977-6740 TTY 1-800-977-6741	Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710
<b>MASSACHUSETTS – Medicaid and CHIP</b>	<b>NEW YORK – Medicaid</b>
Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a> Phone: 1-800-462-1120	Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a> Phone: 1-800-541-2831

<p align="center"><b>MINNESOTA – Medicaid</b></p> <p>Website: <a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a>  Click on Health Care, then Medical Assistance  Phone: 1-800-657-3629</p>	<p align="center"><b>NORTH CAROLINA – Medicaid</b></p> <p>Website: <a href="http://www.ncdhhs.gov/dma">http://www.ncdhhs.gov/dma</a>  Phone: 919-855-4100</p>
<p align="center"><b>MISSOURI – Medicaid</b></p> <p>Website:  <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>  Phone: 573-751-2005</p>	<p align="center"><b>NORTH DAKOTA – Medicaid</b></p> <p>Website:  <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a>  Phone: 1-800-755-2604</p>
<p align="center"><b>OKLAHOMA – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>  Phone: 1-888-365-3742</p>	<p align="center"><b>UTAH – Medicaid and CHIP</b></p> <p>Website: <a href="http://health.utah.gov/upp">http://health.utah.gov/upp</a>  Phone: 1-866-435-7414</p>
<p align="center"><b>OREGON – Medicaid</b></p> <p>Website: <a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a>  <a href="http://www.hijosaludablesoregon.gov">http://www.hijosaludablesoregon.gov</a>  Phone: 1-800-699-9075</p>	<p align="center"><b>VERMONT – Medicaid</b></p> <p>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a>  Phone: 1-800-250-8427</p>
<p align="center"><b>PENNSYLVANIA – Medicaid</b></p> <p>Website: <a href="http://www.dpw.state.pa.us/hipp">http://www.dpw.state.pa.us/hipp</a>  Phone: 1-800-692-7462</p>	<p align="center"><b>VIRGINIA – Medicaid and CHIP</b></p> <p>Medicaid Website: <a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a>  Medicaid Phone: 1-800-432-5924  CHIP Website: <a href="http://www.famis.org/">http://www.famis.org/</a>  CHIP Phone: 1-866-873-2647</p>
<p align="center"><b>RHODE ISLAND – Medicaid</b></p> <p>Website: <a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a>  Phone: 401-462-5300</p>	<p align="center"><b>WASHINGTON – Medicaid</b></p> <p>Website:  <a href="http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx">http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx</a>  Phone: 1-800-562-3022 ext. 15473</p>
<p align="center"><b>SOUTH CAROLINA – Medicaid</b></p> <p>Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a>  Phone: 1-888-549-0820</p>	<p align="center"><b>WEST VIRGINIA – Medicaid</b></p> <p>Website: <a href="http://www.dhhr.wv.gov/bms/">www.dhhr.wv.gov/bms/</a>  Phone: 1-877-598-5820, HMS Third Party Liability</p>
<p align="center"><b>SOUTH DAKOTA - Medicaid</b></p> <p>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>  Phone: 1-888-828-0059</p>	<p align="center"><b>WISCONSIN – Medicaid</b></p> <p>Website: <a href="http://www.badgercareplus.org/pubs/p-10095.htm">http://www.badgercareplus.org/pubs/p-10095.htm</a>  Phone: 1-800-362-3002</p>
<p align="center"><b>TEXAS – Medicaid</b></p> <p>Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a>  Phone: 1-800-440-0493</p>	<p align="center"><b>WYOMING – Medicaid</b></p> <p>Website:  <a href="http://health.wyo.gov/healthcarefin/equalitycare">http://health.wyo.gov/healthcarefin/equalitycare</a>  Phone: 307-777-7531</p>
<p align="center"><b>OKLAHOMA – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>  Phone: 1-888-365-3742</p>	<p align="center"><b>UTAH – Medicaid and CHIP</b></p> <p>Website: <a href="http://health.utah.gov/upp">http://health.utah.gov/upp</a>  Phone: 1-866-435-7414</p>

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

## PART A: General Information

When key parts of the health care law take effect in 2014. There will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act. You may be eligible for a tax credit.<sup>1</sup>

**Note:** *If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after tax basis.*

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact [Blue Shield of Northeastern New York, Customer Service 888-840-6322](http://www.BlueShieldNY.com)

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](http://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

<sup>1</sup> An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.



# New Health Insurance Marketplace Coverage Options and Your Health Coverage

## PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name <b>CITY OF PLATTSBURGH</b>		4. Employer Identification Number <b>14-6002376</b>	
5. Employer address <b>41 CITY HALL PLACE</b>		6. Employer phone number <b>518-563-7704</b>	
7. City <b>PLATTSBURGH</b>	8. State <b>NEW YORK</b>	9. ZIP code <b>12901</b>	
10. Who can we contact about employee health coverage at this job? <b>ANN GIARD-CHASE, PHR</b>			
11. Phone number (if different from above) <b>518-536-7527</b>		12. Email address <b>CHASEA@CITYOFPLATTSBURGH-NY.GOV</b>	

Here is some basic information about health coverage offered by this employer:

- **As your employer, we offer a health plan to:**
  - All employees.
  - Some employees. Eligible employees are:
    - 1) A regularly scheduled full-time or part-time employee of the City of Plattsburgh who works a minimum of 35 hrs. per week (full-time) or 25 hrs. per week (part-time), after the 30 day new hire probationary period.
    - 2) A retiree of the City of Plattsburgh
    - 3) Eligible for coverage by Council Resolution or Bargaining Agreement
- **With respect to dependents:**
  - We do offer dependent coverage. Eligible dependents are:
 

Legal spouse, unless legally separated from you, domestic partner (Fire, Police, Library only), married or unmarried child from birth to 26<sup>TH</sup> birthday.
  - We do not offer coverage.
- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

\*\* Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](http://HealthCare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](http://HealthCare.gov) to find out if you can get a tax credit to lower your monthly premiums.

