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Ask your provider if the services you need are preventive. Then check what your plan will pay for. Flu vaccine covered in full out-of-network. | | **If you have a test** | Diagnostic test (x-ray, blood work) | $‎10 copayment | 30% coinsurance | No Routine OON | | Imaging (CT/PET scans, MRIs) | $‎10 copayment | 30% coinsurance | None | | **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available at [www.bcbswny.com](http://www.bcbswny.com/) | Generic drugs (Tier 1) | $‎5 copayment | Not covered | Some generic drugs may be subject to non-preferred brand cost share. | | Preferred brand drugs (Tier 2) | $‎20 copayment | Not covered | None | | Non-preferred brand drugs (Tier 3) | $‎40 copayment | Not covered | None | | Specialty drugs (Tier 4) | See limitations & exceptions | See limitations & exceptions | Specialty drugs could be generic, preferred brand or non-preferred brand. Please visit our website for a copy of our medication guide. | | **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $‎10 copayment | 30% coinsurance | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. | | Physician/surgeon fees | Covered in full | 30% coinsurance | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. | | **If you need immediate medical attention** | Emergency room care | $‎50 copayment | Covered as in-network | Prudent layperson language applies | | Emergency medical transportation | $‎50 copayment | Covered as in-network | None | | Urgent care | $‎35 copayment | Covered as in-network | None | | **If you have a hospital stay** | Facility fee (e.g., hospital room) | Covered in full | 30% coinsurance | Prior authorization required. No limit In-Network. 365 days per stay OON. | | Physician/surgeon fees | Covered in full | 30% coinsurance | None | | **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $‎10 copayment for Mental Health; $‎10 copayment for Substance Abuse | 30% coinsurance for Mental Health; 30% coinsurance for Substance Abuse | None | | Inpatient services | Covered in full for Mental Health; Covered in full for Substance Abuse Detox; Covered in full for Substance Abuse Rehab | 30% coinsurance for Mental Health; 30% coinsurance for Substance Abuse Detox; 30% coinsurance for Substance Abuse Rehab | Prior authorization required. | | **If you are pregnant** | Office visits | $‎10 copayment | 30% coinsurance | None | | Childbirth/delivery professional services | $‎10 copayment | 30% coinsurance | For participating providers, cost share applies only to initial visit to determine pregnancy. | | Childbirth/delivery facility services | Covered in full | 30% coinsurance | None | | **If you need help recovering or have other special health needs** | Home health care | $‎10 copayment | 30% coinsurance | 200 (in+OON) visits per plan year for home care, including home infusion therapy | | Rehabilitation services | $‎10 copayment | 30% coinsurance | 60 visits, aggregate IN & OON with PT/OT/ST, per plan year | | Skilled nursing care | Covered in full | 30% coinsurance | Prior authorization required. 50 days per plan year IN + OON aggregate limit | | Durable medical equipment | $0 per stay | 50% coinsurance | Prior authorization required on certain procedures. Call the number on the back of your ID card for details. | | Hospice services | $‎10 copayment | 30% coinsurance | Prior authorization required. 210 days per plan year aggregate INN & OON | | **If your child needs dental or eye care** | Children’s eye exam | $‎10 copayment | 30% coinsurance | Member cost share may vary by plan. | | Children’s glasses | See limitations & exceptions | See limitations & exceptions | Discounts may apply. | | Children’s dental check-up | See limitations & exceptions | See limitations & exceptions | Contact your group administrator for coverage details. | | |  | | |  | | --- | | **Excluded Services & Other Covered Services:** | | **Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)** | | |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  | | --- | | * Cosmetic surgery | | * Hearing Aids | | * Routine Foot Care | |  | |  | | --- | | * Custodial Care | | * Long Term Care | | * Weight Loss Programs | |  | |  | | --- | | * Dental | | * Private Duty Nursing | | |  |  |  | | |  | | **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)** | | |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  | | --- | | * Acupuncture | | * Elective Abortion | | * Routine Eye Care (Adult) | |  | |  | | --- | | * Bariatric surgery | | * Infertility treatment | |  | |  | | --- | | * Chiropractic care | | * Non-emergency care when traveling outside the U.S. | | |  |  |  |  | | |  | | **Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.healthcare.gov/) or call 1-800-318-2596. | | **Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-888-249-2583. | | **Does this plan provide Minimum Essential Coverage? Yes**  If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month. | | **Does this plan meet Minimum Value Coverage? Yes**  If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. | | **Language Access Services:**  Spanish (Español): Para obtener asistencia en Español, llame al 1-888-249-2583.  Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-249-2583.  Chinese (中文):如果需要中文的帮助，请拨打这个号码 1-888-249-2583. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-249-2583.  ––––––––––––––––––––––*To see examples of how this plan might cover costs for a sample medical situation, see the next section.–––––––––––*––––––––––– | | | |
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Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles](https://www.healthcare.gov/sbc-glossary/#deductible), [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). Please note these coverage examples are based on self-only coverage. | |  | |  |  |  | |  |  |  |  | |  |  |  |  |  | | | | | | | | | |  |  |  |  |  |  |  |  | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | |  | | --- | | **Peg is Having a Baby** | | (9 months of in-network pre-natal care and a hospital delivery) | | |  | |  |  |  |  | | |  |  | | --- | --- | |  **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | **$1,500.00** | |  [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$10.00** | |  **Hospital (facility)** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$0** | |  **Other** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$10.00** | | | |  | |  |  |  |  | |  | |  | | --- | | **This EXAMPLE event includes services like:**  Specialist office visits (*prenatal care)*  Childbirth/Delivery Professional Services  Childbirth/Delivery Facility Services  Diagnostic tests (*ultrasounds and blood work)*  Specialist visit *(anesthesia)* | | | | |  |  |  |  | |  | |  |  | | --- | --- | | **Total Example Cost** | **$12,919** | |  |  | |  |  |  |  | |  | |  |  | | --- | --- | | **In this example, Peg would pay:** | | | *Cost Sharing* | | | Deductibles\* | $1,500 | | Copays | $390 | | Coinsurance | $0 | | *What isn’t covered* | | | Limits or exclusions | $60 | | **The total Peg would pay is** | **$1,950** | | |  | | |  | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | |  | | --- | | **Managing Joe’s type 2 Diabetes** | | (a year of routine in-network care of a well-controlled condition) | | |  | |  |  |  |  | | |  |  | | --- | --- | |  **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | **$1,500.00** | |  [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$10.00** | |  **Hospital (facility)** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$0** | |  **Other** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$10.00** | | | |  | |  |  |  |  | |  | |  | | --- | | **This EXAMPLE event includes services like:**  Primary care physician office visits (*including disease education)*  Diagnostic tests *(blood work)*  Prescription drugs  Durable medical equipment *(glucose meter)* | | | | |  |  |  |  | |  | |  |  | | --- | --- | | **Total Example Cost** | **$7,431** | |  |  | |  |  |  |  | |  | |  |  | | --- | --- | | **In this example, Joe would pay:** |  | | *Cost Sharing* | | | Deductibles\* | $1,500 | | Copays | $675 | | Coinsurance | $0 | | *What isn’t covered* | | | Limits or exclusions | $55 | | **The total Joe would pay is** | **$2,230** | | |  | |  | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | |  | | --- | | **Mia’s Simple Fracture** | | (in-network emergency room visit and  follow up care) | | |  | |  |  |  |  | | |  |  | | --- | --- | |  **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | **$1,500.00** | |  [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$10.00** | |  **Hospital (facility)** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$0** | |  **Other** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | **$10.00** | | | |  | |  |  |  |  | |  | |  | | --- | | **This EXAMPLE event includes services like:**  Emergency room care *(including medical*  *supplies)*  Diagnostic test *(x-ray)*  Durable medical equipment *(crutches)*  Rehabilitation services *(physical therapy)* | | | | |  |  |  |  | |  | |  |  | | --- | --- | | **Total Example Cost** | **$1,925** | |  |  | |  |  |  |  | |  | |  |  | | --- | --- | | **In this example, Mia would pay:** |  | | *Cost Sharing* | | | Deductibles\* | $1,500 | | Copays | $230 | | Coinsurance | $0 | | *What isn’t covered* | | | Limits or exclusions | $0 | | **The total Mia would pay is** | **$1,730** | | |  | | |  | |  |  |  |  |  |  |  |  | |  | |  | | --- | | Note: These numbers assume the patient does not participate in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) wellness program.  If you participate in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) wellness program, you may be able to reduce your costs.  For more information about the wellness program, please contact: BlueCross BlueShield of Western New York at www.bcbswny.com or call 1-888-249-2583.  \*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. | | | | | |  |  | | | |
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