TO: Instructional Employees

FROM: Human Resource Dept

HEALTH INSURANCE RATES

2019-2020

CDPHP (EPO) RATES

for employees hired **PRIOR** to February 1, 1994

	TOTAL	EMPLOYERS SHARE-85%	EMPLOYEES SHARE-15%	21 PAYROLL DEDUCTIONS
IND.	$ 9,380.15	$ 7,973.13	$ 1,407.02	$ 67.01
2 PERSON	$ 18,589.27	$ 15,800.88	$ 2,788.39	$ 132.79
FAMILY	$ 24,902.11	$ 21,166.79	$ 3,735.32	$ 177.88
MEDICARE	$ 9,380.15			

for employees hired **AFTER** to February 1, 1994

	TOTAL	EMPLOYERS SHARE-82%	EMPLOYEES SHARE-18%	21 PAYROLL DEDUCTIONS
IND.	$ 9,380.15	$ 7,691.73	$ 1,688.43	$ 80.41
2 PERSON	$ 18,589.27	$ 15,243.20	$ 3,346.07	$ 159.34
FAMILY	$ 24,902.11	$ 20,419.73	$ 4,482.38	$ 213.45
MEDICARE	$ 9,380.15			

for employees hired **AFTER** July 1, 2015

	TOTAL	EMPLOYERS SHARE-80%	EMPLOYEES SHARE-20%	21 PAYROLL DEDUCTIONS
IND.	$ 9,380.15	$ 7,504.12	$ 1,876.03	$ 89.34
2 PERSON	$ 18,589.27	$ 14,871.42	$ 3,717.85	$ 177.05
FAMILY	$ 24,902.11	$ 19,921.68	$ 4,980.42	$ 237.16
MEDICARE	$ 9,380.15			

BS PPO (812) RATES

for employees hired **PRIOR** to February 1, 1994

	TOTAL	EMPLOYERS BASE PLAN SHARE	EMPLOYEES SHARE-15%	EMPLOYEES SHARE	21 PAYROLL DEDUCTIONS
IND.	$ 11,074.69	$ 7,973.13	$ -	$ 3,101.56	$ 147.69
2 PERSON	$ 28,444.14	$ 15,800.88	$ -	$ 12,643.26	$ 602.06
FAMILY	$ 29,857.98	$ 21,166.79	$ -	$ 8,691.19	$ 413.87
MEDICARE	$ 8,642.07				

for employees hired **AFTER** to February 1, 1994

	TOTAL	EMPLOYERS BASE PLAN SHARE	EMPLOYEES SHARE-18%	EMPLOYEES SHARE	21 PAYROLL DEDUCTIONS
IND.	$ 11,074.69	$ 7,691.73	$ -	$ 3,382.97	$ 161.09
2 PERSON	$ 28,444.14	$ 15,243.20	$ -	$ 13,200.94	$ 628.62
FAMILY	$ 29,857.98	$ 20,419.73	$ -	$ 9,438.25	$ 449.44
MEDICARE	$8,642.07				

for employees hired **AFTER** July 1, 2015

	TOTAL	EMPLOYERS BASE PLAN SHARE	EMPLOYEES SHARE-20%	EMPLOYEES SHARE	21 PAYROLL DEDUCTIONS
IND.	$ 11,074.69	$ 7,504.12	$ -	$ 3,570.57	$ 170.03
2 PERSON	$ 28,444.14	$ 14,871.42	$ -	$ 13,572.72	$ 646.32
FAMILY	$ 29,857.98	$ 19,921.68	$ -	$ 9,936.30	$ 473.16
MEDICARE	$ 8,642.07				

Dependents to 26

Contact Susan Radley - Benefits Ext 7234

TO: Instructional Employees

FROM: Human Resource Dept

DENTAL AND VISION INSURANCE RATES

2019-2020

DELTA DENTAL	TOTAL	EMPLOYERS SHARE UP TO $355	EMPLOYEES SHARE	21 PAYROLL DEDUCTIONS
IND.	$ 305.64	$ 295.00	$ 10.64	$ 0.51
FAMILY	$ 928.08	$ 177.50	$ 750.58	$ 35.74

DAVIS VISION	TOTAL	EMPLOYERS SHARE UP TO $355	EMPLOYEES SHARE	21 PAYROLL DEDUCTIONS
IND.	$ 68.84	$ 60.00	$ 8.84	$ 0.42
FAMILY	$ 341.93	$ 177.50	$ 164.43	$ 7.83

DELTA DENTAL & DAVIS VISION COMBINED	TOTAL	EMPLOYERS SHARE UP TO $355	EMPLOYEES SHARE	21 PAYROLL DEDUCTIONS
IND.	$ 374.48	$ 355.00	$ 19.48	$ 0.93
FAMILY	$ 1,270.01	$ 355.00	$ 915.01	$ 43.57

FAMILY DENTAL & INDIVIDUAL VISION	TOTAL	EMPLOYERS SHARE UP TO $355	EMPLOYEES SHARE	21 PAYROLL DEDUCTIONS
IND.	$ 68.84	$ 60.00	$ 8.84	$ 0.42
FAMILY	$ 928.08	$ 295.00	$ 633.08	$ 30.15

FAMILY VISION & INDIVIDUAL DENTAL	TOTAL	EMPLOYERS SHARE UP TO $355	EMPLOYEES SHARE	21 PAYROLL DEDUCTIONS
IND.	$ 305.64	$ 177.50	$ 128.14	$ 6.10
FAMILY	$ 341.93	$ 177.50	$ 164.43	$ 7.83

Dependents to 26

Contact Susan Radley - Benefits Ext 7234

CDPHP ® EPO Plan Benefit Summary

Plan Code: AVPARK119
Group ID: 10000888
Presented For: Averill Park Central School District
Date Prepared: 6/21/2019
Effective Date: 10/01/2019

	In-Network
Deductible	N/A Single / N/A Family
Coinsurance	Not Applicable
Office Visits	
PCP	$25 Copayment
Live Video Doctor Visits	$25 Copayment
Specialist	$25 Copayment
Out of Pocket Maximum	$5,925 Single / $11,850 Family (Embedded)
Annual Benefit Maximum	Unlimited
Physician Services	
PCP Office Visits for illness, injury or second opinion	$25 Copayment
Specialist Office Visits for illness, injury or second opinion	$25 Copayment
Physician Visits during inpatient stay when billed separately from the facility	Covered in full
Chemotherapy/Radiation Therapy	$25 Copayment
Well Baby and Child Care including immunizations and inoculations	Covered in full
Annual Adult Exam	Covered in full
Annual Gynecological Exam	Covered in full
Hospital Services	
Inpatient Hospital (semi-private room, anesthesia, X-Ray, lab tests, etc)	$250 Copayment
Newborn Nursery	Covered in full
Outpatient Surgery	$100 Copayment
Diagnostic Testing*	
Outpatient Hospital Laboratory Services: * Copayment waived if provider is a freestanding or designated laboratory.	$25 Copayment
Outpatient Hospital Radiology Services: * Copayment waived if is a preferred center.	$25 Copayment
Office Based Laboratory Services: * Copayment waived if provider is a freestanding or designated laboratory.	$25 Copayment
Office Based Radiology Services: * Copayment waived if is a preferred center.	$25 Copayment
Mammogram	Covered in full
Cytology Screening	Covered in full
Prostate Cancer Screening	Covered in Full
Emergency Care	
Worldwide Emergency Room Care	$150 Copayment
Ambulance	$150 Copayment
Urgent Care	
Nonparticipating urgent care facility services within the CDPHP UBI service area are not covered	$35 Copayment
Physical Therapy	$25 Copayment (120 visits per benefit period)
Speech Therapy	$25 Copayment (60 visits per benefit period)
Occupational Therapy	$25 Copayment (120 visits per benefit period)
Home Health Care	Covered in full

CDPHP ® EPO Plan Benefit Summary

Plan Code: AVPARK119
Group ID: 10000888
Presented For: Averill Park Central School District
Date Prepared: 6/21/2019
Effective Date: 10/01/2019

Your employer has chosen the following rider(s) to modify the Plan under which you would be covered as a CDPHP Member.

Additional Benefits	
Rider Name	COPAY
Description	Inpatient Copayments Limited to 2 for Individual & 3 for Family per Plan Year
DME Riders	
Rider Name	DME2
Description	Durable medical equipment, prosthetics, orthotics, and oxygen are covered at 20% coinsurance in-network. There is no coverage for orthotic shoe inserts.
Domestic Partnership	
Rider Name	ELG12
Description	Provides coverage for an eligible same or opposite sex domestic partner and his or her eligible dependent children.
Medicare Split Family Rider	
Rider Name	ELGMC
Description	Medicare Split Family Rider
Surviving Spouse	
Rider Name	ELG17
Description	Extends eligibility for surviving spouse and dependents upon the death of the subscriber.
Vision Coverage	
Rider Name	VSN2
Description	One routine eye exam is available every 24 months, commencing on the group effective date, without referral, refer to specialist office visit for cost share.

UBI : AVPARK119 **Coverage for:** All Tiers | **Plan Type:** EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-269-2134 . For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cdphp.com/contracts or call 1-877-269-2134 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this **plan** covers.
Are there services covered before you meet your deductible?	No.	See the Common Medical Events chart below for your costs for services this **plan** covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $5,925 individual/ $11,850 family.	If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums, balance billed** charges, and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.cdphp.com or call 1-877-269-2134 for a list of **network providers** .	This **plan** uses a **provider network.** You will pay less if you use a **provider** in the plan's **network.** You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays **(balance billing).** Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.cdphp.com/Members/Rx-Corner	Tier 1 drugs	Not Covered	Not Covered	None.
	Tier 2 drugs	Not Covered	Not Covered	
	Tier 3 drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 co-pay /visit	Not Covered	You may have reduced cost share for preferred ambulatory surgery centers.
	Physician/surgeon fees	No Charge	Not Covered	None.
If you need immediate medical attention	Emergency room care	$150 co-pay /visit	$150 co-pay /visit	All Emergency Care is considered In-Network.
	Emergency medical transportation	$150 co-pay /visit	$150 co-pay /visit	All Emergency Care is considered In-Network.
	Urgent care	$35 **co-pay** /visit	$35 **co-pay** /visit	You may use **live video visits**.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 **co-pay** /visit	Not Covered	Prior authorization required for continuous confinement services and inpatient stays.
	Physician/surgeon fees	No Charge	Not Covered	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	$250 **co-pay** /visit	Not Covered	Limited to 90 days per benefit period. If you do not secure authorization before receiving care, you can be held responsible for an additional payment of 50% of the allowed amount, up to $500 per service, in addition to your usual cost-share.
	Durable medical equipment	20% **co-insurance**	Not Covered	Durable medical equipment that is rented, repaired, replaced or costs more than $1000 requires prior authorization before receiving care, otherwise you can be held responsible for an additional payment of 50% of the allowed amount, up to $500 per service, in addition to your usual cost-share. Shoe inserts are not covered.
	Hospice services	$250 **co-pay** /visit	Not Covered	Limited to 210 days combined Inpatient and Outpatient.
If your child needs dental or eye care	Children's eye exam	$25 **co-pay** /visit	Not Covered	One routine eye exam is available every 24 months.
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	Preventive Dental is not covered under your medical benefits.

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 as follows: Contact CDPHP at 1-877-269-2134 (or TTY 711),The New York State of Health NYS Department of Financial Services at (800) 342-3736 or **http://www.dfs.ny.gov/**, the Health Insurance Assistance Team of the U.S. Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or **www.cciio.cms.gov**, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html**.

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** I. 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: CDPHP at 1-877-269-2134 (or TTY 711), The New York State of Health NYS Department of Financial Services at (800) 342-3736 or **http://www.dfs.ny.gov/**, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**.

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

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

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

Discrimination is Against the Law

Capital District Physicians' Health Plan, Inc. (CDPHP®) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CDPHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CDPHP:

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

If you need these services, contact the CDPHP Civil Rights Coordinator.

If you believe that CDPHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: CDPHP Civil Rights Coordinator, 500 Patroon Creek Blvd., Albany, NY 12206, 1-844-391-4803 (TTY/TDD: 711), Fax (518) 641-3401. You can file a grievance by mail, fax, or electronically at https://www.cdphp.com/customer-support/email-cdphp. If you need help filing a grievance, the CDPHP Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201,
1-800-368-1019 (TDD 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-language Interpreter Services

ATTENTION: If you speak a non-English language, language assistance services, free of charge, are available to you. Call the number on your member ID card (TTY: 711).

ATENCIÓN: Si habla otro idioma que no es el inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación de miembro (TTY: 711).

注意：如果您使用的語言不是英語，您可以免費獲得語言援助服務。請致電您會員 ID 卡上的電話（聽力障礙電傳：711）。

BlueShield
of Northeastern New York

Averill Park Central School
Express Scripts Prescription Drug Plan

	Generic Drug	Brand Name Drug	Non-Formulary Generic & Brand Name Drug
Retail Copayment	$2	$25	$40
Mail Order Copayment (90 day supply)	$4	$50	$80
Providers	***Member must utilize a participating Medco Pharmacy provider.***		

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.bseny.com or call 1-800-888-1238. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-888-249-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Does not apply,	Does not apply.
Are there services covered before you meet your deductible?	Does not apply,	Does not apply.
Are there other deductibles for specific services?	Does not apply.	Does not apply,
What is the out-of-pocket limit for this plan?	For network providers $1,980 individual / $3,960 family.	If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bseny.com com or call 1-800-888-1238 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the in-network specialist you choose without permission from this plan.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not applicable	Not applicable	This is a prescription drug only plan
	Specialist visit	Not applicable	Not applicable	This is a prescription drug only plan
	Preventive care/screening/ immunization	Not applicable	Not applicable	This is a prescription drug only plan
If you have a test	Diagnostic test (x-ray, blood work)	Not applicable	Not applicable	This is a prescription drug only plan
	Imaging (CT/PET scans, MRIs)	Not applicable	Not applicable	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bsneny.com	Generic drugs (Tier 1)	$2 co-pay/prescription	Not covered	$4 co-pay per 90 day supply for mail order. $50 co-pay per 90 day supply for mail order. $80 co-pay per 90 day supply for mail order. Specialty drugs could be generic, preferred brand, or non-preferred brand. For Member Service related to prescriptions call 1-866-591-3878.
	Preferred brand drugs (Tier 2)	$25 co-pay/prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	$40 co-pay/prescription	Not covered	
	Specialty drugs (Tier 4)	See Limitations and Exceptions	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	Not applicable	This is a prescription drug only plan
	Physician/surgeon fees	Not applicable	Not applicable	This is a prescription drug only plan
If you need immediate medical attention	Emergency room care	Not applicable	Not applicable	This is a prescription drug only plan
	Emergency medical transportation	Not applicable	Not applicable	
	Urgent care	Not applicable	Not applicable	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	Not applicable	This is a prescription drug only plan
	Physician/surgeon fees	Not applicable	Not applicable	This is a prescription drug only plan

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Long Term Care
- Weight Loss Programs
- Cosmetic surgery
- Custodial Care
- Private Duty Nursing
- Dental (Adult)
- Hearing Aids
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery Bariatric Surgery
- Infertility treatment
- Chiropractic Care
- Routine Eye Care (Adult)
- Elective Abortion
- 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 are the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 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 Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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.

BlueShield of Northeastern New York

1-800-888-1238 bsneny.com

Benefit Summary for Group:

CASHIC-Averill Park CSD

Effective Date: 7/1/2019

	PPO 812		
	In-Network	Out-of-Network	Additional Information
General Information			
Provider Network	PPO Network		
Deductible	N/A	$250 single / $500 family	
Deductible Administration Type	None	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Coinsurance	N/A	20% coinsurance after deductible	
Out of Pocket Maximum	$4,500 single / $9,000 family	$2,500 single / $5,000 family	
Out of Pocket Administration Type	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	Embedded - On family plans, one person cannot exceed the individual deductible and/or out of pocket maximum amount.	
Benefit Administration Date	1/1		
Dependent Coverage			
Dependent Age	26/26		
Dependent Coverage Ends	End of birth month		
Domestic Partner and Children	Includes coverage for domestic partner only		
Prescription Drug Coverage			
Prescription Drugs	$5 generic/$10 brand	Not Covered	
Mail Order	$10 generic/$20 brand copayment per 90 day supply	Not Covered	
Prescription Deductible	No		

	PPO 812		
	In-Network	Out-of-Network	Additional Information
Hospital Services			
Inpatient Hospital	Covered in full	20% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	Covered in full	20% coinsurance after deductible	Preauth required for certain procedures. Follow Corporate guidelines.
Skilled Nursing Facility	Covered in full	20% coinsurance after deductible	120 Days
Diagnostic Testing Services			
Laboratory Tests	Covered in full	20% coinsurance after deductible	
Radiology	Covered in full	20% coinsurance after deductible	
Maternity Services			
Physician Services: Prenatal and Postnatal Care (initial visit)	$10 copayment/$10 copayment	20% coinsurance after deductible	
Inpatient Maternity	Covered in full	20% coinsurance after deductible	
Mental Health and Substance Abuse			
Inpatient Mental Health	Covered in full	20% coinsurance after deductible	
Outpatient Mental Health	Covered in full	20% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	Covered in full	20% coinsurance after deductible	
Inpatient Substance Abuse - Detox	Covered in full	20% coinsurance after deductible	
Outpatient Substance Abuse	Covered in full	20% coinsurance after deductible	
Diabetic Supplies and Services			
Diabetic Equipment	$10 copayment	20% coinsurance after deductible	
Insulin and Other Oral Agents	$5/$10 Copayment	20% coinsurance after deductible	
Diabetic Medical Supplies (Test strips, Syringes, etc)	$10 copayment	20% coinsurance after deductible	
Rehabilitation Services			
Chiropractic Care	$10 copayment/$10 copayment	20% coinsurance after deductible	
Physical - Occupational - Speech Therapies	$10 copayment/$10 copayment	20% coinsurance after deductible	60 visits, aggregate IN & OON with PT/OT/ST, per plan year
Pulmonary Rehabilitation	$10 copayment/$10 copayment	20% coinsurance after deductible	24 visits per plan yr in a 12 week period. Aggregate IN + OON

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.bsneny.com or call 1-800-888-1238. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.bsneny.com or call 1-800-888-1238 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: N/A; Out-of-network: $250 individual / $500 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. No services are subject to a deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. This plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $4,500 individual / $9,000 family; Out-of-network: $2,500 individual / $5,000 family	If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bsneny.com or call 1-800-888-1238 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copayment	20% coinsurance	None
	Specialist visit	$10 copayment	20% coinsurance	None
	Preventive care/screening/immunization	Covered in full	20% coinsurance	You may have to pay for services that aren't preventive. 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)	Covered in full	20% coinsurance	No Routine OON
	Imaging (CT/PET scans, MRIs)	Covered in full	20% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bsneny.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)	$10 Copayment	Not covered	None
	Non-preferred brand drugs (Tier 3)	Not covered	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)	Covered in full	20% 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	20% 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	$35 copayment	Covered as in-network	Prudent layperson language applies
	Emergency medical transportation	Covered in full	Covered as in-network	None
	Urgent care	$10 copayment	Covered as in-network	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered in full	20% coinsurance	Prior authorization required.
	Physician/surgeon fees	Covered in full	20% coinsurance	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Cosmetic surgery	• Custodial Care
• Dental	• Hearing Aids	• Long Term Care
• Private Duty Nursing	• Routine Foot Care	• Weight Loss Programs

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

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 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.