NYCDC Carpenters Welfare Fund: City Active

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

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type:** City of NY

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.express-scripts.com or by calling 1-800-939-2091.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 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, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Prescription Drug: **$1,625** Individual/ **$4,062** Family (This out-of-pocket maximum is prorated effective July 1, 2015 through December 31, 2015)	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.express-scripts.com	If you use an in-network pharmacy **provider**, this plan will pay some or all of the costs of covered services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **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 provider's office or clinic	Primary care visit to treat an injury or illness	Not Covered	Not Covered	Since this plan only provides prescription, dental and vision benefits, there is no coverage for this type of medical event. You either must obtain benefits from other coverage that may be available to you or you must pay 100% of these expenses, even in-network.
	Specialist visit	Not Covered	Not Covered	
	Other practitioner office visit	Not Covered	Not Covered	
	Preventive care/ screening/ immunization	Not Covered	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	Since this plan only provides prescription, dental and vision benefits, there is no coverage for this type of medical event. You either must obtain benefits from other coverage that may be available to you or you must pay 100% of these expenses, even in-network.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drug	Retail: $10 copay/Rx Mail Order: $20 copay/Rx	Not Covered	Retail & Mail Order: Member pays the copayment plus the difference in cost between the brand-name drug and the generic drug. Mandatory mail order after the third retail fill for maintenance drugs. Contraceptives and certain preventive medications are available at no cost. Brand-name drugs are only covered if no generic is available. In accordance with Health Reform, certain over-the-counter (OTC) drugs are payable at no charge when prescribed by a physician.
	Formulary Brand name drug	Retail: $20 copay/Rx Mail Order: $40 copay/Rx	Not Covered	
	Non-Formulary Brand name drug	Retail: $35 copay/Rx Mail Order: $70 copay/Rx	Not Covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	Since this plan only provides prescription, dental and vision benefits, there is no coverage for this type of medical event. You either must obtain benefits from other coverage that may be available to you or you must pay 100% of these expenses, even in-network.
	Physician/surgeon fees	Not Covered	Not Covered	
If you need immediate medical attention	Emergency room services	Not Covered	Not Covered	Since this plan only provides prescription, dental and vision benefits, there is no coverage for this type of medical event. You either must obtain benefits from other coverage that may be available to you or you must pay 100% of these expenses, even in-network.
	Emergency medical transportation	Not Covered	Not Covered	
	Urgent care	Not Covered	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	Since this plan only provides prescription, dental and vision benefits, there is no coverage for this type of medical event. You either must obtain benefits from other coverage that may be available to you or you must pay 100% of these expenses, even in-network.
	Physician/surgeon fee	Not Covered	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered	Not Covered	Since this plan only provides prescription, dental and vision benefits, there is no coverage for this type of medical event. You either must obtain benefits from other coverage that may be available to you or you must pay 100% of these expenses, even in-network.
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	
	Substance use disorder outpatient services	Not Covered	Not Covered	
	Substance use disorder inpatient services	Not Covered	Not Covered	

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 are pregnant	Prenatal and postnatal care	Not Covered	Not Covered	Since this plan only provides prescription, dental and vision benefits, there is no coverage for this type of medical event. You either must obtain benefits from other coverage that may be available to you or you must pay 100% of these expenses, even in-network.
	Delivery and all inpatient services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	Since this plan only provides prescription, dental and vision benefits, there is no coverage for this type of medical event. You either must obtain benefits from other coverage that may be available to you or you must pay 100% of these expenses, even in-network.
	Rehabilitation services	Not Covered	Not Covered	
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	Not Covered	Not Covered	
	Hospice service	Not Covered	Not Covered	
If your child needs dental or eye care	Eye exam	No Charge	Charges over $125 combined Plan Allowance	$125 per year reimbursement applies to eye exams, frames and lenses combined.
	Glasses	No Charge	Charges over $125 combined Plan Allowance	
	Dental check-up	No Charge	Reimbursed according to Plan's schedule of allowances	Services are subject to a maximum Fund payment of $2,500 per person per calendar year; Children orthodontia covered up to $1,950 per lifetime.

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
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs
- All items in the "Common Medical Events" on the prior pages except Prescription Drugs for members and Dental and Eye care for children

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.)

- Dental Care (Adult)
- Hearing aids
- Routine eye care (Adult)

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 1-800-529-3863. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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: Express Scripts, 8111 Royal Ridge Parkway, Irving, TX 75063, Attention: Administrative Reviews. You may also contact the Department of Labor's Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform or the New York State Department of Insurance contact: 1-(800) 342-3736. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th floor, New York, NY 10010, (888) 614-5400, http://www.communityhealthadvocates.org/.

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). **Because this Plan only provides prescription drug benefits that are supplemental to the New York City Health Benefits Program, this provision is not applicable. See the SBC form your New York City Health Benefits Program to determine if your coverage meets this standard.**

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $280
- **Patient pays** $7,260

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$80
Coinsurance	$0
Limits or exclusions	$7,180
Total	**$7,260**

The benefit provided under this Supplemental Plan is limited to prescription drug benefits.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,340
- **Patient pays** $2,060

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$600
Coinsurance	$1,030
Limits or exclusions	$430
Total	**$2,060**

The benefit provided under this Supplemental Plan is limited to prescription drug benefits.

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.