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 excellusbcbs.com/IBEW910 or by calling **1-800-499-1275.**

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?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no out-of-pocket limit.	Not applicable because there's no **out-of-pocket limit** on your expenses.
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. See www.excellusbcbs.com/IBEW910 **or call 1-800-499-1275** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some 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 don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	This policy supplements Medicare and only applies to items and services covered by Medicare. If Medicare denies or does not allow a service, this policy will not cover. Some of the services this plan doesn't cover are listed on page 4 & 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	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Specialist visit	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Other practitioner office visit	Acupuncture Not Covered Chiropractic No Charge	Acupuncture Not Covered Chiropractic No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Preventive care/screening/immunization	No Charge	Adult Physical Not Covered Well Child Not Covered Adult Immunizations No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.

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 need drugs to treat your illness or condition **More information about prescription**	Generic drugs	Not Covered	Not Covered	Not Covered
	Preferred brand drugs	Not Covered	Not Covered	Not Covered
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Not Covered	Not Covered	Not Covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Physician/surgeon fees	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
If you need immediate medical attention	Emergency room services	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Emergency medical transportation	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Urgent care	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Physician/surgeon fee	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Mental/Behavioral health inpatient services	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Substance use disorder outpatient services	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Substance use disorder inpatient services	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
If you are pregnant	Prenatal and postnatal care	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Delivery and all inpatient services	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Rehabilitation services	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Habilitation services	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Skilled nursing care	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.

	Durable medical equipment	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
	Hospice service	No Charge	No Charge	This policy supplements Medicare and only applies to items and services covered by Medicare.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

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
- Dental Care (Adult)
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs
- Prescription Drugs

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

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 1-800-499-1275. 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 Customer Service at 1-800-499-1275.

- For group health coverage subject to ERISA, you can contact your plan at 1-800-499-1275. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If coverage is insured, you can contact New York State Department of Financial Services at 1-800-342-3736
- For non-federal governmental group health plans and church plans that are group health plans, call 1-800-499-1275. If coverage is insured, you can contact New York State Department of Financial Services at 1-800-342-3736
- Additionally, a consumer assistance program can help you file your appeal. Contact Community Health Advocates, the State's consumer assistance program, at 1-888-614-5400 or at www.communityhealthadvocates.org.

Language Access Services:

Español: Para obtener asistencia en Español, llame al 1-800-499-1275.

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-499-1275.

中Ł: 如果需要中Ł的帮助，请拨扰这个号码 1-800-499-1275.

Dine: Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-499-1275.

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: $6,660
- Patient pays: $880

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	$0
Coinsurance	$0
Limits or exclusions	$880
Total	$880

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

- Amount owed to providers: $5,400
- Plan pays: $4,520
- Patient pays: $880

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	$0
Coinsurance	$0
Limits or exclusions	$880
Total	$880

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 **1-800-499-1275** or visit us at **excellusbcbs.com/IBEW910.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the glossary at **www.cciio.cms.gov** or call **1-800-499-1275** to request a copy.