

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 1-800-499-1275 or visit Our website at www.excellusbcbs.com. 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.ccio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Out-of-Network: \$500 Individual/\$1,000 Two Person/\$1,500 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	Yes, Preventive Care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, 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: \$4,200 Individual/\$8,400 Two Person/\$12,600 Family; Out-of-Network: \$4,620 Individual/\$9,240 Two Person/\$13,860 Family	The out-of-pocket limit is the most you could pay in a year for covered services. 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?	Costs for 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.excellusbcbs.com or call 1-800-499-1275 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
		In-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	\$15 <u>Copay</u> /visit No Charge for Members to age 19	20% <u>Coinsurance</u>	None
	<u>Specialist visit</u>	\$25 <u>Copay</u> /visit	20% <u>Coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge	Adult Physical: 20% <u>Coinsurance</u> Adult Immunizations: 20% <u>Coinsurance</u> Well Child Visit: No Charge	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. 1 Exam per calendar year
	<u>Diagnostic test</u> (x-ray, blood work)	X-Ray: \$25 <u>Copay</u> /visit Blood Work: No Charge	X-Ray: 20% <u>Coinsurance</u> Blood Work: 20% <u>Coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	\$25 <u>Copay</u> /visit	20% <u>Coinsurance</u>	
	Tier 1 (Generic drugs)	\$5/prescription retail, \$10/prescription mail order No Charge Members to age 19	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription
	Tier 2 (Preferred brand drugs)	\$25/prescription retail, \$50/prescription mail order	Not Covered	<u>Preauthorization</u> required for certain <u>prescription drugs</u> . If you don't get a <u>preauthorization</u> , you must pay the entire cost of the drug.
	Tier 3 (Non-preferred brand drugs)	\$50/prescription retail, \$100/prescription mail order	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$75 <u>Copay</u>	20% <u>Coinsurance</u>	None
	Physician/surgeon fees	No Charge	20% <u>Coinsurance</u>	
	<u>Emergency room care</u>	\$75 <u>Copay</u> /visit	\$75 <u>Copay</u> /visit	None
	<u>Emergency medical transportation</u>	\$75 <u>Copay</u> /visit	\$75 <u>Copay</u> /visit <u>Deductible</u> does not apply	None
If you need immediate medical attention	<u>Urgent care</u>	\$25 <u>Copay</u> /visit	20% <u>Coinsurance</u>	None
	Facility fee (e.g., hospital room)	\$150 <u>Copay</u>	20% <u>Coinsurance</u>	None
	Physician/surgeon fees	No Charge	20% <u>Coinsurance</u>	
	Outpatient services	\$15 <u>Copay</u> /visit	20% <u>Coinsurance</u>	
If you have a hospital stay	Inpatient services	\$150 <u>Copay</u>	20% <u>Coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services				

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No Charge	20% Coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge	20% Coinsurance	None
	Childbirth/delivery facility services	No Charge	20% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	No Charge	20% Coinsurance	<u>Deductible</u> is limited to \$50 Out-of-Network 40 Visits per year limit
	Rehabilitation services	\$25 Copay/visit	20% Coinsurance	45 Visits per year limit
	Habilitation services	\$25 Copay/visit	20% Coinsurance	45 Visits per year limit
	Skilled nursing care	\$150 Copay	20% Coinsurance	45 Days per year limit
	Durable medical equipment	20% Coinsurance	20% Coinsurance	None
	Hospice services	No Charge	20% Coinsurance	Family bereavement counseling limited to 5 Visits per year
If your child needs dental or eye care	Children's eye exam	\$25 Copay/visit	20% Coinsurance	1 Exam per year
	Children's glasses	20% Coinsurance	20% Coinsurance	1 Pair Per year
	Children's dental check-up	Not Covered	Not Covered	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.)	
• Cosmetic surgery	• Dental care (Adult)
• Long-term care	• Dental care (Child)
• Weight loss programs	• Private-duty nursing
	• Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Acupuncture	• Bariatric surgery
• Hearing aids	• Chiropractic care
• Routine eye care (Adult)	• Infertility treatment
	• 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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. 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: the phone number on Your ID card or www.excellusbcbs.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc> and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

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.-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. 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 overall deductible** \$0
- **Specialist copayment** \$25
- **Hospital (facility) copayment** \$150
- **Other coinsurance** 20%

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	\$12,700
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In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$50
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$110

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$0
- **Specialist copayment** \$25
- **Hospital (facility) copayment** \$150
- **Other coinsurance** 20%

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	\$5,600
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In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$760
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$780

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$0
- **Specialist copayment** \$25
- **Hospital (facility) copayment** \$150
- **Other coinsurance** 20%

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	\$2,800
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In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$280
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$330

The plan would be responsible for the other costs of these EXAMPLE covered services.

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- 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, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan 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:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

