

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Excellus BCBS: Healthy Blue Copay \$30 copay

A nonprofit independent licensee of the BlueCross BlueShield Association

Finger Lakes Area School Health Plan

Coverage Period: 07/01/2023 - 06/30/2024

Coverage for: Family | Plan Type: PPO

 **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.cchio.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 <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>
Are there services covered before you meet your deductible?	Yes, <u>Preventive Care</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> 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 <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Costs for <u>premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	\$30 <u>Copay</u> /visit No Charge for Members to age 19	20% <u>Coinsurance</u>	None
	<u>Specialist</u> visit	\$50 <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 year
	<u>Diagnostic test</u> (x-ray, blood work)	X-Ray: \$50 <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)	\$50 <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)	\$35/prescription retail, \$70/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)	\$70/prescription retail, \$140/prescription mail order	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>Copay</u>	20% <u>Coinsurance</u>	None
	Physician/surgeon fees	No Charge	20% <u>Coinsurance</u>	
	<u>Emergency room care</u>	\$250 <u>Copay</u> /visit	\$250 <u>Copay</u> /visit	None
	<u>Emergency medical transportation</u>	\$250 <u>Copay</u> /visit	<u>Deductible</u> does not apply	None
If you need immediate medical attention	<u>Urgent care</u>	\$50 <u>Copay</u> /visit	20% <u>Coinsurance</u>	None
	Facility fee (e.g., hospital room)	\$500 <u>Copay</u>	20% <u>Coinsurance</u>	None
	Physician/surgeon fees	No Charge	20% <u>Coinsurance</u>	
	Outpatient services	\$30 <u>Copay</u> /visit	20% <u>Coinsurance</u>	None
If you have a hospital stay	Inpatient services	\$500 <u>Copay</u>	20% <u>Coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services				

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	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No Charge	20% Coinsurance	None
	Childbirth/delivery facility services	No Charge	20% Coinsurance	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	20% Coinsurance	<u>Deductible</u> is limited to \$50 Out-of-Network 40 Visits per year limit
	<u>Rehabilitation services</u>	\$50 Copay/visit	20% Coinsurance	45 Visits per year limit
	<u>Habilitation services</u>	\$50 Copay/visit	20% Coinsurance	45 Visits per year limit
	<u>Skilled nursing care</u>	\$500 Copay	20% Coinsurance	45 Days per year limit
	<u>Durable medical equipment</u>	20% Coinsurance	20% Coinsurance	None
	<u>Hospice services</u>	No Charge	20% Coinsurance	Family bereavement counseling limited to 5 Visits per year
	Children's eye exam	\$50 Copay/visit	20% Coinsurance	1 Exam per year
If your child needs dental or eye care	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)
- Dental care (Child)
- 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**.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- 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 <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](#) \$50
- [Hospital \(facility\) copayment](#) \$500
- [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	\$100
Coinsurance	\$0
Limits or exclusions	
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$160

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](#) \$50
- [Hospital \(facility\) copayment](#) \$500
- [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	\$1,270
Coinsurance	\$0
Limits or exclusions	
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,290

Mia's Simple Fracture

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

- The [plan's overall deductible](#) \$0
- [Specialist copayment](#) \$50
- [Hospital \(facility\) copayment](#) \$500
- [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	\$750
Coinsurance	\$50
Limits or exclusions	
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$800

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>.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anviòp la pou jwenn fason pou kontakte nou.

주요해 주제어: 한국어 사용을 사랑하는 것은, 곧 평범한 언어자를 사랑한다는 것을, 곧 우리 자신을 사랑하는 것을 뜻한다. 언어와 민족은

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

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Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

[illegible]

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

[illegible]

Panunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning librang tulong sa wika. Mangyaring sumangguni sa nakalagip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν ημετέρε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας
δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους
τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

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