

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.bcbswny.com](http://www.bcbswny.com) or call 1-888-839-5169. 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.bcbswny.com](http://www.bcbswny.com) or call 1-888-839-5169 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In- <a href="#">network</a> : N/A; Out-of- <a href="#">network</a> : \$250 individual / \$500 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. No services are subject to a <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. This <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In- <a href="#">network</a> : \$5,000 individual / \$10,000 family; Out-of- <a href="#">network</a> : \$2,000 individual / \$4,000 family  \$3,700 individual / \$7,400 family for in-network pharmacies	If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bcbswny.com">www.bcbswny.com</a> or call 1-888-839-5169 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$10 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$10 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening</a> /immunization	Covered in full	20% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. Flu vaccine covered in full out-of- <a href="#">network</a> .
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$10 <a href="#">copayment</a> for x-ray, Covered in full for blood work	20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	\$10 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> 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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbswny.com">www.bcbswny.com</a>	Generic drugs (Tier 1)	\$2 <a href="#">copayment</a>	<a href="#">Not covered</a>	Some generic drugs may be subject to non-preferred brand <a href="#">cost share</a> .
	Preferred brand drugs (Tier 2)	\$20 <a href="#">copayment</a>	<a href="#">Not covered</a>	None
	Non-preferred brand drugs (Tier 3)	\$35 <a href="#">copayment</a>	<a href="#">Not covered</a>	None
	<a href="#">Specialty drugs</a> (Tier 4)	See limitations & exceptions	See limitations & exceptions	<a href="#">Specialty drug</a> s 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)	\$10 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details.
	Physician/surgeon fees	Covered in full	20% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$50 <a href="#">copayment</a>	Covered as in- <a href="#">network</a>	None
	<a href="#">Emergency medical transportation</a>	\$50 <a href="#">copayment</a>	Covered as in- <a href="#">network</a>	None
	<a href="#">Urgent care</a>	\$10 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 per stay	20% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required.

	Physician/surgeon fees	Covered in full	20% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$10 <a href="#">copayment</a> for Mental Health; \$10 <a href="#">copayment</a> for Substance Abuse	20% <a href="#">coinsurance</a> for Mental Health; 20% <a href="#">coinsurance</a> for Substance Abuse	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
	Inpatient services	\$0 per stay for Mental Health; \$0 per stay for Substance Abuse Detox; \$0 per stay for Substance Abuse Rehab	20% <a href="#">coinsurance</a> for Mental Health; 20% <a href="#">coinsurance</a> for Substance Abuse Detox; 20% <a href="#">coinsurance</a> for Substance Abuse Rehab	<a href="#">Prior authorization</a> required.
<b>If you are pregnant</b>	Office visits	\$10 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	PCP copay on initial visit only.
	Childbirth/delivery professional services	\$10 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	For participating <a href="#">providers</a> , <a href="#">cost share</a> applies only to initial visit to determine pregnancy.
	Childbirth/delivery facility services	\$0 per stay	20% <a href="#">coinsurance</a>	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$10 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	No copay for early maternity discharge; unlimited in-net; max 365 agg all Home Care OON red by # rec in-net
	<a href="#">Rehabilitation services</a>	\$10 <a href="#">copayment</a>	20% <a href="#">coinsurance</a>	20 aggregate PT/OT/ST visits per calendar year; aggregate IN & OON. Additional visits may be allowed if determined to be medically necessary. Treatment <a href="#">Plan</a> after the 20th visit.
	<a href="#">Skilled nursing care</a>	\$0 per stay	20% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required. Unlimited Days
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details.
	<a href="#">Hospice services</a>	Covered in full	20% <a href="#">coinsurance</a>	210 days per calendar year INN & OON aggregate
<b>If your child needs dental or eye care</b>	Children's eye exam	See limitations & exceptions	See limitations & exceptions	Member <a href="#">cost share</a> may vary by <a href="#">plan</a> .
	Children's glasses	See limitations & exceptions	See limitations & exceptions	Discounts may apply.
	Children's dental check-up	See limitations & exceptions	See limitations & exceptions	Contact your group administrator for coverage details.

**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
- Dental
- Private-duty nursing
- Cosmetic surgery
- Hearing aids
- Routine foot care
- Custodial care
- Long-term 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
- Infertility treatment
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Elective Abortion
- 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](http://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](http://www.HealthCare.gov) or call 1-888-839-5169.

**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 on how 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: 1-888-839-5169.

**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 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 1-888-839-5169.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-839-5169.

Chinese (中文):如果需要中文的帮助, 请拨打这个号码1-888-839-5169.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-839-5169.

—————*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0.00
■ <a href="#">Specialist copayment</a>	\$10.00
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$10.00

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

Cost Sharing	
Deductibles*	\$0
Copays	\$30
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$90</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0.00
■ <a href="#">Specialist copayment</a>	\$10.00
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$10.00

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

Cost Sharing	
Deductibles*	\$0
Copays	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$320</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0.00
■ <a href="#">Specialist copayment</a>	\$10.00
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$10.00

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

Cost Sharing	
Deductibles*	\$0
Copays	\$200
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$250</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: BlueCross BlueShield of Western New York at [www.bcbswny.com](http://www.bcbswny.com) or call 1-888-839-5169.

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.