

 **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](http://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.cciio.cms.gov](http://www.cciio.cms.gov) or [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-499-1275 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                          | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | In-Network: \$3,500 Individual/ \$7,000 Family; Out-of-Network: \$3,850 Individual/ \$7,700 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 policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.                                                                                                                                                                                                                                                                                                                                             |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes, <a href="#">Preventive Care</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. For example, 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> .                                                                      |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No                                                                                                                                               | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | In-Network: \$5,000 Individual/\$10,000 Family; Out-of-Network: \$5,500 Individual/\$11,000 Family                                               | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | Costs for <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a> or call 1-800-499-1275 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 <a href="#">out-of-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 <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | No                                                                                                                                               | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|  All <a href="#">copayment</a> and <a href="#">coinsurance</a> costs shown in this chart are after your <a href="#">deductible</a> has been met, if a <a href="#">deductible</a> applies. |                                                        |                                                                                                                                         |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Common Medical Event                                                                                                                                                                                                                                                        | Services You May Need                                  | What You Will Pay                                                                                                                       |                                                                                                                                        | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                             |                                                        | In-Network Provider<br>(You will pay the least)                                                                                         | Out-of-Network Provider<br>(You will pay the most)                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                                                               | Primary care visit to treat an injury or illness       | 20% <a href="#">Coinsurance</a>                                                                                                         | 40% <a href="#">Coinsurance</a>                                                                                                        | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                             | <a href="#">Specialist</a> visit                       | 20% <a href="#">Coinsurance</a>                                                                                                         | 40% <a href="#">Coinsurance</a>                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                             | <a href="#">Preventive care/screening/immunization</a> | Adult Physical: No Charge<br>Adult Immunizations: No Charge<br>Well Child Visit: No Charge<br><a href="#">Deductible</a> does not apply | Adult Physical: 40% <a href="#">Coinsurance</a><br>Adult Immunizations: 40% <a href="#">Coinsurance</a><br>Well Child Visit: No Charge | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. 1 Exam per calendar year                                                                                                                                                                                                                                      |
| <b>If you have a test</b>                                                                                                                                                                                                                                                   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | X-Ray: 20% <a href="#">Coinsurance</a><br>Blood Work: 20% <a href="#">Coinsurance</a>                                                   | X-Ray: 40% <a href="#">Coinsurance</a><br>Blood Work: 40% <a href="#">Coinsurance</a>                                                  | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                             | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">Coinsurance</a>                                                                                                         | 40% <a href="#">Coinsurance</a>                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                             | Tier 1 (Generic drugs)                                 | \$5/prescription retail, \$10/prescription mail order<br>No Charge Members to age 19                                                    | Not Covered                                                                                                                            | Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).                                                                                                                                                                                                             |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.excellusbcbs.com</a>                                                                                       | Tier 2 (Preferred brand drugs)                         | \$45/prescription retail, \$90/prescription mail order                                                                                  | Not Covered                                                                                                                            | Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Cost-Sharing for epinephrine auto-injector devices shall not exceed \$100 per Plan Year.<br>Most generic drugs are included in Tier 1; however, some generic drugs may also be included in Tier 2 or Tier 3 |
|                                                                                                                                                                                                                                                                             | Tier 3 (Non-preferred brand drugs)                     | \$90/prescription retail, \$180/prescription mail order                                                                                 | Not Covered                                                                                                                            | Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription<br><a href="#">Preauthorization</a> required for certain <a href="#">prescription drugs</a> . If you don't get a <a href="#">preauthorization</a> , you must pay the entire cost and submit a claim to us for reimbursement.                                                                                                                                             |

| Common Medical Event                                                             | Services You May Need                            | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                              |
|----------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                     |
| <b>If you have outpatient surgery</b>                                            | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
|                                                                                  | Physician/surgeon fees                           | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    |                                                                                                                                                                                                                                                     |
|                                                                                  | <a href="#">Emergency room care</a>              | 20% <a href="#">Coinsurance</a>                 | 20% <a href="#">Coinsurance</a>                    | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency medical transportation</a> | 20% <a href="#">Coinsurance</a>                 | 20% <a href="#">Coinsurance</a>                    | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
|                                                                                  | <a href="#">Urgent care</a>                      | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
|                                                                                  | Facility fee (e.g., hospital room)               | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
| <b>If you have a hospital stay</b>                                               | Physician/surgeon fees                           | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                              | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    |                                                                                                                                                                                                                                                     |
|                                                                                  | Inpatient services                               | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | None                                                                                                                                                                                                                                                |

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                   |
|-----------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                           | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                          |
| <b>If you are pregnant</b>                                            | Office visits                             | No Charge                                       | 40% <a href="#">Coinsurance</a>                    | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .                                                                                                                                                    |
|                                                                       | Childbirth/delivery professional services | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. |
|                                                                       | Childbirth/delivery facility services     | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | None                                                                                                                                                                                                                                     |
|                                                                       | <a href="#">Home health care</a>          | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | None                                                                                                                                                                                                                                     |
|                                                                       | <a href="#">Rehabilitation services</a>   | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | 45 Visits per plan year limit. The visit limit does not apply to <a href="#">Rehabilitation Services</a> for a mental health condition or substance use disorder.                                                                        |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Habilitation services</a>     | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | 45 Visits per plan year limit. The visit limit does not apply to <a href="#">Habilitation Services</a> for a mental health condition or substance use disorder.                                                                          |
|                                                                       | <a href="#">Skilled nursing care</a>      | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | 45 Days per plan year limit. The visit limit does not apply to Skilled Nursing Care for a mental health condition or substance use disorder.                                                                                             |
|                                                                       | <a href="#">Durable medical equipment</a> | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | None                                                                                                                                                                                                                                     |
|                                                                       | <a href="#">Hospice services</a>          | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | Family bereavement counseling limited to 5 Visits per plan year                                                                                                                                                                          |
|                                                                       | Children's eye exam                       | 20% <a href="#">Coinsurance</a>                 | 40% <a href="#">Coinsurance</a>                    | 1 Exam per year                                                                                                                                                                                                                          |
| <b>If your child needs dental or eye care</b>                         | Children's glasses                        | Not Covered                                     | Not Covered                                        | None                                                                                                                                                                                                                                     |
|                                                                       | 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

\* For more information about limitations and exceptions, see [plan](#) or policy document at [www.excellusbcbs.com](http://www.excellusbcbs.com)

- Hearing aids
- 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](http://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.excelluscbcs.com](http://www.excelluscbcs.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](http://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](http://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](mailto:cha@cssny.org) or [www.communityhealthadvocates.org](http://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/CCI0/Resources/Consumer-Assistance-Grants](http://www.cms.gov/CCI0/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](#) \$3,500
- [Coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [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 |
|--------------------|----------|

**In this example, Peg would pay:**

| Cost Sharing               |         |
|----------------------------|---------|
| Deductibles                | \$3,500 |
| Copayments                 | \$0     |
| Coinsurance                | \$1,500 |
| What isn't covered         |         |
| Limits or exclusions       | \$20    |
| The total Peg would pay is | \$5,020 |

Managing Joe's type 2 Diabetes

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

- The [plan's overall deductible](#) \$3,500
- [Coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [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 |
|--------------------|---------|

**In this example, Joe would pay:**

| Cost Sharing               |         |
|----------------------------|---------|
| Deductibles                | \$3,500 |
| Copayments                 | \$30    |
| Coinsurance                | \$380   |
| What isn't covered         |         |
| Limits or exclusions       | \$20    |
| The total Joe would pay is | \$3,930 |

Mia's Simple Fracture

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

- The [plan's overall deductible](#) \$3,500
- [Coinsurance](#) 20%
- [Hospital \(facility\) coinsurance](#) 20%
- [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 |
|--------------------|---------|

**In this example, Mia would pay (This condition is not covered, so patient pays 100%):**

| Cost Sharing               |         |
|----------------------------|---------|
| Deductibles                | \$2,800 |
| Copayments                 | \$0     |
| Coinsurance                | \$0     |
| What isn't covered         |         |
| Limits or exclusions       | \$0     |
| The total Mia would pay is | \$2,800 |

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, sexual orientation, gender identity, or sex (consistent with the scope of sex discrimination as described at 45CFR section 92.10(a)(2)). The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, gender identity, 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, sexual orientation, gender identity, or sex; you can file a grievance with the Health Plan's Section 1557 Coordinator at:

Advocacy Department  
Attn: Civil Rights Coordinator  
PO Box 4717  
Syracuse, NY 13221  
Email: [Advocacy.Department@excellus.com](mailto:Advocacy.Department@excellus.com)  
Telephone number: 1-800-614-6575  
TTY number: 1-800-662-1220  
Fax: 1-315-671-6656

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, 1-800-537-7697 (TDD)  
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at Excellus BlueCross BlueShield's website at: [www.ExcellusBCBS.com](http://www.ExcellusBCBS.com)

## Notice of Availability of Language Assistance Services

|                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. To access these services, please call us at 1-877-626-9298 (TTY: 1-800-662-1220).                                                                     |
| ATENCIÓN: Si habla español, tiene disponible servicios gratuitos de asistencia lingüística. También hay disponible de manera gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Para acceder a estos servicios, llámenos al 1-877-626-9298 (TTY: 1-800-662-1220).                                                  |
| انتباه: إذا كنت تتحدث العربية فإن خدمات مساعدة اللغة المجانية مُناحة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. للوصول إلى هذه الخدمات، يُرجى الاتصال بنا على الرقم 1-877-626-9298 (الهاتف النصي: 1-800-662-1220).                                                                                       |
| 注意：如果您說中文，我們可以為您提供免費的語言幫助。我們也可以為您免費提供適當的輔助工具和服務，以無障礙格式提供資訊。要獲得這些服務，請撥打 1-877-626-9298（TTY：1-800-662-1220）。                                                                                                                                                                                                                                                             |
| ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services supplémentaires appropriés pour fournir des informations dans des formats accessibles sont aussi disponibles gratuitement. Pour accéder à ces services, veuillez nous appeler au 1 877 626 9298 (TTY [ATS] : 1 800 662 1220). |
| দৃষ্টি আকর্ষণ: আপনি যদি বাংলাতেও কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সাহায্য এবং পরিষেবাগুলি ও বিনামূল্যে উপলব্ধ। এই পরিষেবাগুলি অ্যাক্সেস করার জন্য, অনুগ্রহ করে আমাদের 1-877-626-9298 (TTY: 1-800-662-1220) নম্বরে কল করুন।                                                 |
| ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги языковой поддержки. Также бесплатно доступны соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах. Чтобы воспользоваться этими услугами, позвоните нам по номеру 1-877-626-9298 (TTY: 1-800-662-1220).                                      |
| ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू तपाईंका लागि उपलब्ध छन्। सुलभ ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। यी सेवाहरू उपयाेग गर्न, कृपया हामीलाई 1-877-626-9298 (TTY: 1-800-662-1220) मा फोन गर्नुहोस्।                                                                        |
| УВАГА: Якщо Ви говорите українською, Вам доступні безкоштовні послуги мовної підтримки. Відповідні допоміжні засоби та послуги для надання інформації в доступних форматах також надаються безкоштовно. Щоб скористатися цими послугами, зателефонуйте нам за номером: 1-877-626-9298 (TTY [Телетайп]: 1-800-662-1220).                                                |

FIIRO-GAAR AH: Haddii aad ku hadashid Soomaali, adeeggyada caawimaada luuqadda oo bilaashka ah ayaad helayaa. Agabka caawimaada naafada iyo adeeggyo ku habboon oo lagu bixinaayo macluumaadka qaabab la helo karo ayaa sidoo kale lagu heli karaa bilaa lacag. Si loo helo adeegyadaan, fadlan naga soo wac 1-877-626-9298 (TTY: 1-800-662-1220).

ဟ်သုဉ်ဟ်သး- နမ့ၣ်ကတိၤအဲကလံးကျိၣ်န့ၣ်, တၢ်တိၤစၢၤမၤစၢၤကျိၣ် တၢ်မၤစၢၤတၢ်မၤ အကလီၤအိၣ်လၢနဂီၢ် လၢနမၤန့ၢ်အီၤသ့လီၤ. တၢ်မၤစၢၤတၢ်န့ၢ်ဟူပီးလီၤ ဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအဘၣ်ဘျိးဘၣ်ဒါတဖၣ် ကဟ့ၣ်လီၤ တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢကျိၤကျဲလၢတၢ်န့ၢ်လီၤမၤန့ၢ်အီၤသ့တဖၣ် စ့ၢ်ကီး အိၣ်လၢနမၤန့ၢ်အီၤသ့ လၢတလိၣ်ဟ့ၣ်အပူၤဘၣ်န့ၢ်လီၤ. လၢကမၤန့ၢ်တၢ်မၤစၢၤတၢ်မၤတဖၣ်အံၤအဂီၢ်, ဝံသးစူၤ ကိးပုၤဖဲ 1-877-626-9298 (TTY: 1-800-662-1220).

သတိပြုရန်- သင် မြန်မာ ပြောဆိုလျှင် ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို သင့်အတွက် အခမဲ့ရရှိနိုင်သည်။ မသန်စွမ်းသူများ အသုံးပြုနိုင်သည့် ဖောမတ်များဖြင့် အချက်အလက်များ ပံ့ပိုးပေးနိုင်သည့် သင့်လျော်သော ထောက်ကူပစ္စည်းများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့ရရှိနိုင်ပါသည်။ ဤဝန်ဆောင်မှုများကို ရရှိရန် ကျွန်ုပ်တို့ကို 1-877-626-9298 (TTY- 1-800-662-1220) သို့ ဖုန်းခေါ်ဆိုပါ။

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Để sử dụng các dịch vụ này, vui lòng gọi cho chúng tôi theo số 1-877-626-9298 (TTY: 1-800-662-1220).

ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòm aksesib yo disponib tou gratis. Pou jwenn aksè nan sèvis sa yo, tanpri rele nou nan 1-877-626-9298 (TTY: 1-800-662-1220).

توجه: اگر به زبان دری صحبت می کنید، خدمات کمک زبان رایگان برای شما قابل دسترس است. کمک امدادی مناسب و خدمات برای دسترسی به معلومات در فرمت میسر بصورت مجانی ارائه می شود. برای دسترسی به این خدمات، با این شماره ها تماس حاصل کنید (TTY: 1-800-662-1220) 1-877-626-9298.

TAHADHARI: Ikiwa unazungumza Kiswahili, huduma za usaidizi wa lugha bila malipo zinapatikana kwa ajili yako. Misaada ya ziada inayofaa na huduma za kutoa habari katika miundo inayofikika zinapatikana pia bila malipo Ili kupata huduma hizi, tafadhali tupigie simu kwa 1-877-626-9298 (TTY: 1-800-662-1220).