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.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: $1,800 Individual/ $3,600 Family; Out-of-Network: $3,600 Individual/ $7,200 Family</td>
<td>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 policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes, Preventive Care</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: $3,600 Individual/ $7,200 Family; Out-of-Network: $7,200 Individual/ $14,400 Family</td>
<td>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, the overall family out-of-pocket limit must be met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Costs for premiums, balance billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a> or call 1-800-499-1275 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td><strong>Primary care visit to treat an injury or illness</strong></td>
<td>10% <strong>Coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Specialist visit</strong></td>
<td>10% <strong>Coinsurance</strong></td>
</tr>
</tbody>
</table>
| | **Preventive care/screening/immunization** | Adult Physical: No Charge
Adult Immunizations: No Charge
Well Child Visit: No Charge | Adult Physical: 20% **Coinsurance**
Adult Immunizations: 20% **Coinsurance**
Well Child Visit: No Charge | You may have to pay for services that aren’t preventive. Ask your **provider** if the services needed are preventive. Then check what your **plan** will pay for. 1 Exam per year |
| **If you have a test** | **Diagnostic test** (x-ray, blood work) | X-Ray: 10% **Coinsurance**
Blood Work: 10% **Coinsurance** | X-Ray: 20% **Coinsurance**
Blood Work: 20% **Coinsurance** | None |
| | Imaging (CT/PET scans, MRIs) | 10% **Coinsurance** | 20% **Coinsurance** | None |
| **If you need drugs to treat your illness or condition** | **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 prescription); 90-day supply (mail order prescription)
Preauthorization required. If you don’t get a preauthorization, you must pay the entire cost and submit a claim to us for reimbursement. |
<p>| | <strong>Tier 2 (Preferred brand drugs)</strong> | $35/prescription retail, $70/prescription mail order | Not Covered |  |
| | <strong>Tier 3 (Non-preferred brand drugs)</strong> | $70/prescription retail, $140/prescription mail order | Not Covered |  |
| <strong>If you have outpatient surgery</strong> | Facility fee (e.g., ambulatory surgery center) | 10% <strong>Coinsurance</strong> | 20% <strong>Coinsurance</strong> | None |
| | Physician/surgeon fees | 10% <strong>Coinsurance</strong> | 20% <strong>Coinsurance</strong> | None |
| <strong>If you need immediate medical attention</strong> | <strong>Emergency room care</strong> | 10% <strong>Coinsurance</strong> | 10% <strong>Coinsurance</strong> | None |
| | <strong>Emergency medical transportation</strong> | 10% <strong>Coinsurance</strong> | 10% <strong>Coinsurance</strong> | None |
| | <strong>Urgent care</strong> | 10% <strong>Coinsurance</strong> | 20% <strong>Coinsurance</strong> | None |
| <strong>If you have a hospital stay</strong> | Facility fee (e.g., hospital room) | 10% <strong>Coinsurance</strong> | 20% <strong>Coinsurance</strong> | None |
| | Physician/surgeon fees | 10% <strong>Coinsurance</strong> | 20% <strong>Coinsurance</strong> | None |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge</td>
<td>20% Coinsurance</td>
<td>Cost sharing does not apply for preventive services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, a copayment, coinsurance, or deductible may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>45 Visits per contract year limit</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>45 Visits per contract year limit</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>45 Days per year limit</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>Family bereavement counseling limited to 5 Visits per year</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>1 Exam per contract year</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

**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
- Bariatric surgery
- Chiropractic care

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com
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. 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/ebsa/healthreform; 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: www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.----------------------------------------------------------

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com
### 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: $1,800
- Coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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**: $12,820

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,080</td>
</tr>
</tbody>
</table>

**What isn't covered**

| Limits or exclusions  | $60     |

The total Peg would pay is: **$2,950**

---

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible: $1,800
- Coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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**: $7,460

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$80</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$510</td>
</tr>
</tbody>
</table>

**What isn't covered**

| Limits or exclusions  | $60     |

The total Joe would pay is: **$2,450**

---

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible: $1,800
- Coinsurance: 10%
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 10%

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**: $1,970

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

**What isn't covered**

| Limits or exclusions  | $0      |

The total Mia would pay is: **$1,810**

---

The plan would be responsible for the other costs of these EXAMPLE covered services.
Complaint forms are available at website://www.hhs.gov/ocr/office/hipp.html.
1-800-368-1094, 888-257-7697 (TDD)
Washington, DC 20201
Room 209F, HHB Building 200 Independence Avenue, SW
U.S. Department of Health and Human Services

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 website://www.hhs.gov/ocr/portal/lobby.jsf. By phone at:

Fax: 315-671-6566
TTY number: 1-800-421-1222
Telephone number: 1-800-614-6575
Service: NY 13224
Attn: Civil Rights Coordinator

Advocacy Department

Grievance with:


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 complaint in person, by mail, by phone, or by fax.

If you need help filling a grievance, the Health Plan’s Civil Rights Coordinator is available to help you.

Fax: 315-671-6566
TTY number: 1-800-421-1222
Telephone number: 1-800-614-6575
Service: NY 13224
Attn: Civil Rights Coordinator

Advocacy Department

Grievance with:


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 complaint in person, by mail, by phone, or by fax.

If you need help filling a grievance, the Health Plan’s Civil Rights Coordinator is available to help you.

Fax: 315-671-6566
TTY number: 1-800-421-1222
Telephone number: 1-800-614-6575
Service: NY 13224
Attn: Civil Rights Coordinator

Advocacy Department

You can file a grievance in person or by mail or fax. If you need help filling a grievance, the Health Plan’s Civil Rights Coordinator is available to help you.

Fax: 315-671-6566
TTY number: 1-800-421-1222
Telephone number: 1-800-614-6575
Service: NY 13224
Attn: Civil Rights Coordinator

Advocacy Department

Grievance with:


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 complaint in person, by mail, by phone, or by fax.

If you need help filling a grievance, the Health Plan’s Civil Rights Coordinator is available to help you.

Fax: 315-671-6566
TTY number: 1-800-421-1222
Telephone number: 1-800-614-6575
Service: NY 13224
Attn: Civil Rights Coordinator

Advocacy Department

Grievance with:


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 complaint in person, by mail, by phone, or by fax.

If you need help filling a grievance, the Health Plan’s Civil Rights Coordinator is available to help you.

Fax: 315-671-6566
TTY number: 1-800-421-1222
Telephone number: 1-800-614-6575
Service: NY 13224
Attn: Civil Rights Coordinator

Advocacy Department

Notice of Nondiscrimination

The Health Plan:

Not our discrimination because of race, color, national origin, age, disability, or sex.

Our Health Plan complies with federal civil rights laws.

Notice of Nondiscrimination