### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>Out-of-Network: $750 Individual/$1,500 Two Person/$2,250 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></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><strong>Are there other deductibles for specific services?</strong></td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$4,200 Individual/$8,400 Two Person/$12,600 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Costs for penalties for failure to obtain preauthorization for services, 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><strong>Will you pay less if you use a network provider?</strong></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><strong>Do you need a referral to see a specialist?</strong></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>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 Copay/visit</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$20 Copay/visit</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>Adult Physical: No Charge</td>
<td>Adult Physical: 30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Adult Immunizations: No Charge</td>
<td>Adult Immunizations: Not Covered</td>
</tr>
<tr>
<td></td>
<td>Well Child Visit: No Charge</td>
<td>Well Child Visit: No Charge</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>X-Ray: $20 Copay/visit</td>
<td>X-Ray: 30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Blood Work: No Charge</td>
<td>Blood Work: 30% Coinsurance</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$20 Copay/visit</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.excellusbcbs.com/rxlist">www.excellusbcbs.com/rxlist</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 (Generic drugs)</td>
<td>$5/prescription retail, $10/prescription mail order</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 2 (Preferred brand drugs)</td>
<td>$15/prescription retail, $30/prescription mail order</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tier 3 (Non-preferred brand drugs)</td>
<td>$30/prescription retail, $60/prescription mail order</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$20 Copay</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room care</td>
<td>$50 Copay/visit</td>
<td>$50 Copay/visit</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>$20 Copay/visit</td>
<td>$20 Copay/visit</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$25 Copay/visit</td>
<td>30% Coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com
<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><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
<td>Preauthorization Required for out-of-network services only. If you don’t get a preauthorization, benefits will be reduced by 50% of Coinsurance up to $500. However, Preauthorization is Not Required for Emergency Admissions</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$20 Copay/visit</td>
<td>30% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
<td>Cost sharing does not apply for preventive services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>No Charge</td>
<td>25% Coinsurance</td>
<td>Deductible is limited to $50 Out-of-Network Preauthorization Required. If you don’t get a preauthorization, benefits will be reduced by 50% of Coinsurance up to $500.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$20 Copay/visit</td>
<td>30% Coinsurance</td>
<td>45 Visits per year limit</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$20 Copay/visit</td>
<td>30% Coinsurance</td>
<td>45 Visits per year limit</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
<td>45 Days Per Year limit</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% Coinsurance</td>
<td>30% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
<td>Family bereavement counseling limited to 5 Visits per year</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>$20 Copay/visit</td>
<td>30% Coinsurance</td>
<td>1 Exam per calendar 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>None</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Dental care (Child)</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
</tbody>
</table>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<table>
<thead>
<tr>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
</tbody>
</table>

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

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.

* 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network prenatal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Copayment</strong></td>
<td><strong>Copayment</strong></td>
<td><strong>Copayment</strong></td>
</tr>
<tr>
<td>$20</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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 | $5,600 | $2,800 |

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$40</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $60 |

The total Peg would pay is $100

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$950</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $20 |

The total Joe would pay is $970

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$170</td>
<td>$50</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $20 |

The total Mia would pay is $220

The plan would be responsible for the other costs of these EXAMPLE covered services.
Complaint forms are available at: https://www.practitioner.gov/offices/hhuoffice/file/instructions.
1-800-368-1094, 800-537-7697 (TDD)
Washington, D.C. 20010
Room 209F, HH 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 Compliant Portal, available at https://www.practitioner.gov/offices/hhuoffice/file/instructions.

Health Plan's Civil Rights Coordinator is available to help you.

You can file a grievance in person or by mail or phone. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator can help you. You can file a grievance with:

Fax: 315-471-6656
TTY number: 1-800-471-2220
Telephone number: 1-800-614-6575
Syracuse, NY 13220
PO Box 4717
Attn: Civil Rights Coordinator
Advocate Department

If you believe that your 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:

If you need these services, please refer to the enclosed document for ways to reach us.

Information written in other languages
Qualified interpreters

Provides free language services to people whose primary language is not English, such as:

Written information in other formats (large print, audio, accessible electronic)
Qualified sign language interpreters

Provides free aids and services to people with disabilities to communicate effectively

The Health Plan:

treats them differently because of race, color, national origin, age, disability, or sex. 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.

Notice of Nondiscrimination