



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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$1,700 Individual/ \$3,400 Family; Out-of-Network: \$3,400 Individual/ \$6,800 Family	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.
Are there services covered before you meet your deductible?	Yes, Preventive Care	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: \$3,400 Individual/ \$6,800 Family; Out-of-Network: \$6,800 Individual/ \$13,600 Family	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.
What is not included in the out-of-pocket limit?	Costs for premiums , balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of network providers .	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.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	40% Coinsurance	None
	Specialist visit	20% Coinsurance	40% Coinsurance	
	Preventive care/screening/immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: 40% Coinsurance Adult Immunizations: 40% 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 contract year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: 20% Coinsurance Blood Work: 20% Coinsurance	X-Ray: 40% Coinsurance Blood Work: 40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	
If you need drugs to treat your illness or condition	Tier 1 (Generic drugs)	Not Covered	Not Covered	
	Tier 2 (Preferred brand drugs)	Not Covered	Not Covered	
	Tier 3 (Non-preferred brand drugs)	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	40% Coinsurance	None
	Inpatient services	20% Coinsurance	40% Coinsurance	
If you are pregnant	Office visits	No Charge	40% Coinsurance	Cost sharing does not apply for preventive services .
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	None
	Home health care	20% Coinsurance	40% Coinsurance	None
	Rehabilitation services	20% Coinsurance	40% Coinsurance	45 Visits per contract year limit
	Habilitation services	20% Coinsurance	40% Coinsurance	45 Visits per contract year limit
	Skilled nursing care	20% Coinsurance	40% Coinsurance	45 Days per plan year limit
	Durable medical equipment	20% Coinsurance	40% Coinsurance	None
	Hospice services	20% Coinsurance	40% Coinsurance	Family bereavement counseling limited to 5 Visits per plan year
If your child needs dental or eye care	Children's eye exam	20% Coinsurance	40% Coinsurance	1 Exam per contract year
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	

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
- Long-term care
- Routine foot care
- Dental care (Adult)
- Prescription Drugs
- Weight loss programs
- Dental care (Child)
- Private-duty nursing

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

- Acupuncture
- Hearing aids
- Routine eye care (Adult)
- Bariatric surgery
- Chiropractic care
- 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 or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or www.excellusbcbs.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or

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

www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc> and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	\$1,700
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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,700
Copayments	\$0
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$30
The total Peg would pay is	\$3,430

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	\$1,700
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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,700
Copayments	\$0
Coinsurance	\$730
What isn't covered	
Limits or exclusions	\$100
The total Joe would pay is	\$2,530

Mia's Simple Fracture

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

The plan's overall deductible	\$1,700
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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,700
Copayments	\$0
Coinsurance	\$220
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$1,930

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
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

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).

ATTENCIÓN: 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).

انتباہ: إذا كنت تتحدث العربية فإن خدمات مساعدة اللغة المجانية مُتاحة لك. توفر أيضًا المساعدات والخدمات المنسابة لتوفير المعلومات بتنسيقات يسهل الوصول إليها. لم الوصول إلى هذه الخدمات، يرجى 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 [ATE] : 1 800 662 1220).

දුඩ් ආකර්ෂණ: ආපනි එදි බාංලාතේ කථා බලෙන, තහවුල ඩිනාමුලෝ තැව් සහායතා පරිශ්වවා ආපනාර ජේන ඉපෙළකා ආයාශ්සේසෝග යුතු යායා තේ ප්‍රධානේර ජේන ඉපෙළකා සහායක සාහාය එව් පරිශ්වවාගුලි ට ඩිනාමුලෝ ඉපෙළකා ඇමු පරිශ්වවාගුලි ආයාශ්සේ කරාර ජේන, අනුග්‍රහ කරේ ආමාදේර 1-877-626-9298 (TTY: 1-800-662-1220) තුළේ කළ කරනු।

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).

ଘ୍ୟାନ ଦିନୁହୋସ୍: ତପାଇଁ ନେପାଲୀ ବୌଲୁହନ୍ତ ଭାବେ, ନିଃଶୁଳ୍କ ଭାଷା ସହାୟତା ସେବାହର୍କ ତପାଇଁକା ଲାଗେ ତ୍ୟନଥେ ଛନ୍ତା ମୁଲଭ ଡାଚାହରମା ଜାନକରି ପଦନ ଜର୍ତ୍ତ ତ୍ୟନୁକରି ମହାୟକ ସହାୟତାହର୍କ ର ସେବାହର୍କ ପତି ନିଃଶୁଳ୍କ ତପାଇଁକ ତ୍ୟନଥେ ଛନ୍ତା ଯା ସେବାହର୍କ ତ୍ୟନାଙ୍କ ଗର୍ଜ, କୃପ୍ୟା ହାମୀଲାଇଁ 1-877-626-9298 (TTY: 1-800-662-1220) ମା ଫୋନ ଗର୍ନୁହୋସ୍।

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. Ціоб скористатися цими послугами, зазначеноїмі, зازначеноїмі, зازначеної�ି, ଯାହା ଦିନୁହୋସ୍: ତପାଇଁ ନେପାଲୀ ବୌଲୁହନ୍ତ ଭାବେ, ନିଃଶୁଳ୍କ ଭାଷା ସହାୟତା ସେବାହର୍କ ତପାଇଁକା ଲାଗେ ତ୍ୟନଥେ ଛନ୍ତା ମୁଲଭ ଡାଚାହରମା ଜାନକରି ପଦନ ଜର୍ତ୍ତ ତ୍ୟନୁକରି ମହାୟକ ସହାୟତାହର୍କ ର ସେବାହର୍କ ପତି ନିଃଶୁଳ୍କ ତପାଇଁକ ତ୍ୟନଥେ ଛନ୍ତା ଯା ସେବାହର୍କ ତ୍ୟନାଙ୍କ ଗର୍ଜ, କୃପ୍ୟା ହାମୀଲାଇଁ 1-877-626-9298 (TTY: 1-800-662-1220) ମା ଫୋନ ଗର୍ନୁହୋସ୍।

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

သတိပုံရှိ - သင် ဖြစ်စဉ် ပြေဆိုလိုက် ဘယ်သမာနကားအကြအည့် ဝင်ဆောင်များကို သင်အတောက် အမဲ့ရရှိလိုသည်။ မသင့်ဖွံ့ဖြိုးသများ အသေးပြုခိုင်သည့် ဖောက်တော်များဖြင့် အချက်အလက်များပဲ့ပေါ်လိုသည့် သင်လျှပ်သော ထောက်ကာပွဲများနှင့် ဝန်ဆောင်များကိုလည်း အမဲ့ရရှိပါသည်။
ပြုဝန်ဆောင်မှုများကို ရရှိရန် ကျိုးပိတ်ကို 1-877-626-9298 (PTV- 1-800-662-1220) ထို့
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, sevis assistans lang gratis disponib pou ou. I ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma 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 زیان دری صحبت می کنید، خدمات کمک زیان را گنجان برای شما قابل دسترسی است. کمک امدادی مناسب و خدمات برای دسترسی به معلومات در فرمت میسر بصورت مجازی ارائه می شود. برای دسترسی به این خدمات، با این شماره ها تماس حاصل کنید (TY: 1-800-6662-1220) (1-877-626-9298).

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