




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.excellusbcbcs.com](http://www.excellusbcbcs.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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-499-1275 to request a copy.

| Important Questions  | Answers  | Why This Matters:  |
|--|--|--|
| <p><b>What is the overall <a href="#">deductible</a>?</b></p>                                | <p>For <a href="#">in-network providers</a> and <a href="#">out-of-network providers</a> combined: \$50/ individual or \$150/ family</p>   | <p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>  |
| <p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>    | <p>Yes. Other than office visits, <a href="#">rehabilitation/habilitation</a> services and <a href="#">durable medical equipment</a>, all other services described in this document are covered before you meet your <a href="#">deductible</a>.</p> | <p>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>.</p>   |
| <p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>             | <p>No</p>  | <p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>   |
| <p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p> | <p>Medical (includes <a href="#">deductible</a> and <a href="#">coinsurance</a> maximum): \$450/individual or \$1,350/family<br/><a href="#">Prescription drugs</a>: \$1,000/individual or \$3,000/family</p>  | <p>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>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>  |
| <p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>               | <p>Costs for penalties for failure to obtain <a href="#">preauthorization</a> for services, <a href="#">premiums</a>, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>                          | <p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>  |
| <p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>               | <p>Yes. See <a href="http://www.excellusbcbcs.com">www.excellusbcbcs.com</a> or call 1-800-499-1275 for a list <a href="#">network providers</a>.</p>  | <p>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 a <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.</p> |
| <p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>    | <p>No.</p>   | <p>You can see the <a href="#">specialist</a> you choose without a referral.</p>   |

 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<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>   | 20% <a href="#">coinsurance</a>   | None  |
|   | <a href="#">Specialist</a> visit                       | 20% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>   | None  |
|   | <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: No charge<br>Adult Immunizations: No charge<br>Well Child visit: No charge<br><a href="#">Deductible</a> does not apply | 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. |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge<br><a href="#">Deductible</a> does not apply  | No charge<br><a href="#">Deductible</a> does not apply  | None  |
|   | Imaging (CT/PET scans, MRIs)                           | No charge<br><a href="#">Deductible</a> does not apply  | No charge<br><a href="#">Deductible</a> does not apply  |   |
| <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="http://www.excellusbcbcs.com/rxlist">www.excellusbcbcs.com/rxlist</a> | Generic drugs (Tier 1)                                 | \$1 <a href="#">copay</a> /prescription (retail & mail order)<br><a href="#">Deductible</a> does not apply                              | Not covered   | Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription).  |
|   | Preferred brand drugs (Tier 2)                         | \$5 <a href="#">copay</a> /prescription (retail & mail order)<br><a href="#">Deductible</a> does not apply                              | Not covered   |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)         | No charge<br><a href="#">Deductible</a> does not apply  | No charge<br><a href="#">Deductible</a> does not apply  | None  |
|   | Physician/surgeon fees                                 | No charge<br><a href="#">Deductible</a> does not apply  | No charge<br><a href="#">Deductible</a> does not apply  | None  |

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

| 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)     |  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply | None   |
|   | <a href="#">Emergency medical transportation</a> | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply |  |
|   | <a href="#">Urgent care</a>                      | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply |  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply | None   |
|   | Physician/surgeon fees                           | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply | None   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply | None   |
|   | Inpatient services                               | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply |  |
| If you are pregnant   | Office visits                                    | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply | None   |
|   | Childbirth/delivery professional services        | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply |  |
|   | Childbirth/delivery facility services            | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply |  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply | None   |

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| 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)     |  |
|   | <a href="#">Rehabilitation services</a>   | 20% <a href="#">coinsurance</a>                        | 20% <a href="#">coinsurance</a>                        | Limited to 100 visits per plan year                    |
|   | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a>                        | 20% <a href="#">coinsurance</a>                        |  |
|   | <a href="#">Skilled nursing care</a>      | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply | None   |
|   | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>                        | 20% <a href="#">coinsurance</a>                        | None   |
|   | <a href="#">Hospice services</a>          | No charge<br><a href="#">Deductible</a> does not apply | No charge<br><a href="#">Deductible</a> does not apply | None   |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | Not covered  | Not covered  | None   |
|   | 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](#).)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine eye care (Child)
- 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.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private duty nursing

**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, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov.ebsa/healthreform](http://www.dol.gov.ebsa/healthreform). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318- 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 on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). You may also contact the 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](#).

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Contact Community Service Society of New York, Community Health Advocates, 633 Third Avenue, 10th floor, New York, NY 10017, (888) 614-5400, <http://www.communityhealthadvocates.org/> (website), [cha@cssny.org](mailto:cha@cssny.org) (email). A list of states with Consumer Assistance Programs is available at: [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://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](#) \$50
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |             |
|-----------------------------------|-------------|
| <a href="#">Deductibles</a>       | \$0         |
| <a href="#">Copayments</a>        | \$0         |
| <a href="#">Coinsurance</a>       | \$0         |
| <i>What isn't covered</i>         |             |
| Limits or exclusions              | \$60        |
| <b>The total Peg would pay is</b> | <b>\$60</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$50
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$50         |
| <a href="#">Copayments</a>        | \$40         |
| <a href="#">Coinsurance</a>       | \$400        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$20         |
| <b>The total Joe would pay is</b> | <b>\$510</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$50
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$50         |
| <a href="#">Copayments</a>        | \$0          |
| <a href="#">Coinsurance</a>       | \$200        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$250</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.