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>$50 Individual/$100 Two Person/$150 Family</td>
<td></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>$6,350 Individual/$12,700 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>What is not included in the out-of-pocket limit?</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>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>
</tbody>
</table>
| **If you visit a health care provider’s office or clinic** | Primary care visit to treat an injury or illness  
Specialist visit  
Preventive care/screening/immunization | In-Network Provider (You will pay the least): 20% Coinsurance  
Out-of-Network Provider (You will pay the most): 20% Coinsurance | None |
| **If you have a test** | Diagnostic test (x-ray, blood work)  
Imaging (CT/PET scans, MRIs) | X-Ray: No Charge  
X-Ray: Deductible does not apply  
Blood Work: No Charge  
Blood Work: Deductible does not apply | None |
| **If you need drugs to treat your illness or condition** | Tier 1 (Generic drugs)  
Tier 2 (Preferred brand drugs)  
Tier 3 (Non-preferred brand drugs) | Tier 1 (Generic drugs): $5/prescription retail, $10/prescription mail order  
Tier 2 (Preferred brand drugs): $20/prescription retail, $40/prescription mail order  
Tier 3 (Non-preferred brand drugs): $40/prescription retail, $80/prescription mail order | Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription. Preauthorization required for certain prescription drugs. If you don’t get a preauthorization, you must pay the entire cost of the drug. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center)  
Physician/surgeon fees | Facility fee: No Charge  
Physician/surgeon fees: Deductible does not apply | None |

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>No Charge&lt;br&gt;(You will pay the least)</td>
<td>No Charge&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Charge&lt;br&gt;(You will pay the least)</td>
<td>No Charge&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No Charge&lt;br&gt;(You will pay the least)</td>
<td>No Charge&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>No Charge&lt;br&gt;(You will pay the least)</td>
<td>No Charge&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge&lt;br&gt;(You will pay the least)</td>
<td>No Charge&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>No Charge&lt;br&gt;(You will pay the least)</td>
<td>No Charge&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No Charge&lt;br&gt;(You will pay the least)</td>
<td>No Charge&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No Charge&lt;br&gt;(You will pay the least)</td>
<td>No Charge&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No Charge&lt;br&gt;(You will pay the least)</td>
<td>No Charge&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No Charge&lt;br&gt;(You will pay the least)</td>
<td>No Charge&lt;br&gt;(You will pay the most)</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&lt;br&gt;(You will pay the least)</td>
<td>No Charge&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20%&lt;br&gt;Coinurance&lt;br&gt;(You will pay the least)</td>
<td>20%&lt;br&gt;Coinurance&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20%&lt;br&gt;Coinurance&lt;br&gt;(You will pay the least)</td>
<td>20%&lt;br&gt;Coinurance&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No Charge&lt;br&gt;(You will pay the least)</td>
<td>No Charge&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20%&lt;br&gt;Coinurance&lt;br&gt;(You will pay the least)</td>
<td>20%&lt;br&gt;Coinurance&lt;br&gt;(You will pay the most)</td>
</tr>
<tr>
<td><strong>If your child needs dental</strong></td>
<td>Children’s eye exam</td>
<td>Not Covered&lt;br&gt;(You will pay the least)</td>
<td>Not Covered&lt;br&gt;(You will pay the most)</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>
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<th>In-Network Provider (You will pay the least)</th>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
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</thead>
<tbody>
<tr>
<td>or eye care</td>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></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.)**

- Acupuncture
- Dental care (Child)
- Routine eye care (Adult)
- Weight loss programs
- Cosmetic surgery
- Hearing aids
- Routine eye care (Child)
- Dental care (Adult)
- Long-term care
- Routine foot care

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

- Bariatric surgery
- Chiropractic care
- Private-duty nursing
- Infertility treatment

**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.

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* 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**

- The plan's overall deductible: $50
- Coinsurance: 20%
- Hospital (facility) copayment: $0
- 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:**

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

What isn’t covered

| Limits or exclusions | $60 |

The total Peg would pay is $70

**Managing Joe’s type 2 Diabetes**

- The plan’s overall deductible: $50
- Coinsurance: 20%
- Hospital (facility) copayment: $0
- 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$50</td>
</tr>
<tr>
<td>Copayments</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$150</td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $20 |

The total Joe would pay is $280

**Mia’s Simple Fracture**

- The plan’s overall deductible: $50
- Coinsurance: 20%
- Hospital (facility) copayment: $0
- 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$50</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$140</td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $0 |

The total Mia would pay is $200

The plan would be responsible for the other costs of these EXAMPLE covered services.
Complaint forms are available at http://www.hhs.gov/ocr/office/file/ discrim.html
1-800-368-1094, 800-537-7697 (TDD)
Washington, D.C. 20010
Room 232, HHQ 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 by calling their toll-free civil rights complaint Hotline at 1-800-368-1094 or TDD 1-800-537-7697, or by mail or phone at:

Department of Health and Human Services
Office of Civil Rights
40950 handicapped access agreement
1995 East Jefferson
Ann Arbor, MI 48105

Fax: 313-446-4151
TTY number: 1-800-877-8339
Telephone number: 1-800-877-8339

If you believe that your health plan has failed to provide these services or discriminates in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. If you need help filing a grievance, the grievance coordinator can help you.

Fax: 315-671-6566
TTY number: 1-800-421-1220
Telephone number: 1-800-614-6575

Syracuse, NY 13214
Attn: Civil Rights Coordinator

Health Plans Civil Rights Coordinator is available to help you.

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

- Information written in other languages
- Qualified interpreters
- Documentation written in other forms (large print, audio, electronic
- Qualified sign language interpreters
- Provides free aids and services to people with disabilities to communicate effectively

The Health Plan:

treat 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