**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: $1,800 Individual/ $3,600 Family; Out-of-Network: $3,600 Individual/ $7,200 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: $3,500 Individual/$7,000 Family; Out-of-Network: $7,000 Individual/ $14,000 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<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
| | Specialist visit | 20% Coinsurance | 40% Coinsurance | |
| | Preventive care/screening/ immunization | Adult Physical: No Charge<br>Adult Immunizations: No Charge<br>Well Child Visit: No Charge<br>Deductible does not apply | Adult Physical: 40% Coinsurance<br>Adult Immunizations: 40% Coinsurance<br>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 calendar year |
| **If you have a test** | Diagnostic test (x-ray, blood work) | X-Ray: 20% Coinsurance<br>Blood Work: 20% Coinsurance | X-Ray: 40% Coinsurance<br>Blood Work: 40% Coinsurance | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance | 40% Coinsurance | |
| **If you need drugs to treat your illness or condition**<br>More information about prescription drug coverage is available at www.excellusbcbs.com | Tier 1 (Generic drugs) | $5/prescription retail, $10/ prescription mail order<br>No Charge Members to age 19 | Not Covered | Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Cost-Sharing for epinephrine devices shall not exceed $100 per Plan Year.<br>Most generic drugs are included in Tier 1; however, some generic drugs may also be included in Tier 2 or Tier 3<br>Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription. Specialty drugs may be limited to a 30-day supply/prescription.<br>Preauthorization required for certain prescription drugs. If you don't get a preauthorization, you must pay the entire cost and submit a claim to us for reimbursement. |
| | Tier 2 (Preferred brand drugs) | $35/prescription retail, $70/ prescription mail order | Not Covered | |
| | Tier 3 (Non-preferred brand drugs) | $70/prescription retail, $140/ prescription mail order | Not Covered | |

| 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | 40% Coinsurance | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | |
| **If you need immediate medical attention** | Emergency room care | 20% Coinsurance | 20% Coinsurance | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
| | Emergency medical transportation | 20% Coinsurance | 20% Coinsurance | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
| | Urgent care | 20% Coinsurance | 40% Coinsurance | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% Coinsurance | 40% Coinsurance | None<br>Cost-Sharing for covered services with a primary diagnosis of mental health or substance use disorder may be lower than the Cost-Sharing listed in order to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). |
| | 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 | |

| 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 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. |
| | Childbirth/delivery facility services | 20% Coinsurance | 40% Coinsurance | None |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coinsurance | 40% Coinsurance | None |
| | Rehabilitation services | 20% Coinsurance | 40% Coinsurance | 45 Visits per plan year limit. The visit limit does not apply to Rehabilitation Services for a mental health condition or substance use disorder. |
| | Habilitation services | 20% Coinsurance | 40% Coinsurance | 45 Visits per plan year limit. The visit limit does not apply to Habilitation Services for a mental health condition or substance use disorder. |
| | Skilled nursing care | 20% Coinsurance | 40% Coinsurance | 45 Days per plan year limit. The visit limit does not apply to Skilled Nursing Care for a mental health condition or substance use disorder. |
| | 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 | 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.)**

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

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

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture | • Bariatric surgery | • Chiropractic care |
| • Hearing aids | • Infertility treatment | • Non-emergency care when traveling outside the U.S. |
| • Routine eye care (Adult) | | |

**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 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.––––––––––––––––––*

* 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** | **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** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,800 |
| Copayments | $0 |
| Coinsurance | $1,700 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$3,520** |

### 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** | **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** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,800 |
| Copayments | $50 |
| Coinsurance | $710 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,580** |

### Mia's Simple Fracture

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,800** |
| **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** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,800 |
| Copayments | $10 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,010** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

## 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). |
| ATENCIÓN: 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). |
| انتباه: إذا كنت تتحدث العربية فإن خدمات مساعدة اللغة المجانية مُتاحة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. للوصول إلى هذه الخدمات، يُرجى الاتصال بنا على الرقم 1-877-626-9298 (الهاتف النصي: 1-800-662-1220). |
| 注意：如果您說中文，我們可以爲您提供免費的語言幫助。我們也可以爲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 [*ATS*] : 1 800 662 1220). |
| দৃষ্টি আকর্ষণ: আপনি যদি বাংলাতে কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সাহায্য এবং পরিষেবাগুলি ও বিনামূল্যে উপলব্ধ। এই পরিষেবাগুলি অ্যাক্সেস করার জন্য, অনুগ্রহ করে আমাদের 1-877-626-9298 (TTY: 1-800-662-1220) নম্বরে কল করুন। |
| 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). |
| ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू तपाईंका लागि उपलब्ध छन्। सुलभ ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। यी सेवाहरू उपयोग गर्न, कृपया हामीलाई 1-877-626-9298 (TTY: 1-800-662-1220) मा फोन गर्नुहोस्। |
| 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. Щоб скористатися цими послугами, зателефонуйте нам за номером: 1-877-626-9298 (TTY [*Телетайп*]: 1-800-662-1220). |

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 bixinaayo macluumaadka qaabab la helo karo ayaa sidoo kale lagu heli karaa bilaa lacag. Si loo helo adeegyadaan, fadlan naga soo wac 1-877-626-9298 (TTY: 1-800-662-1220).

ဟ်သူဉ်ဟ်သး- နမ့်ကတိၤအဲကလံးကျိာ်နှဉ်, တ၊်တိစၢၤမၤစၢၤကျိာ် တ၊်မၤစၢၤတ၊်မၤ အကလီအိဉ်လၢနဂီ၊် လၢနမၤန့်၊်အီၤသ့လီၤ. တ၊်မၤစၢၤတ၊်နှ၊်ဟူပီးလီ ဒီး တ၊်မၤစၢၤတ၊်မၤ လၢအဘဉ်ဘျိုးဘဉ်ဒါတဖဉ် ကဟ့ဉ်လီၤ တ၊်ဂ့၊်တ၊်ကျိၤ လၢကျိၤကျဲလၢတ၊်နှာ်လီၤမၤန့်၊်အီၤသ့တဖဉ် စ့၊်ကီး အိဉ်လၢနမၤန့်၊်အီၤသ့ လၢတလိဉ်ဟ့ဉ်အပှၤဘဉ်နှဉ်လီၤ. လၢကမၤန့်၊်တ၊်မၤစၢၤတ၊်မၤတဖဉ်အံၤအဂီ၊်, ဝံသးစူၤ ကိးပှၤဖဲ 1-877-626-9298 (TTY: 1-800-662-1220).

သတိပြုရန်- သင် မြန်မာ ပြောဆိုလျှင် ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို သင့်အတွက် အခမဲ့ရရှိနိုင်သည်။ မသန်စွမ်းသူများ အသုံးပြုနိုင်သည့် ဖောမတ်များဖြင့် အချက်အလက်များ ပံ့ပိုးပေးနိုင်သည့် သင့်လျော်သော ထောက်ကူပစ္စည်းများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့ရရှိနိုင်ပါသည်။ ဤဝန်ဆောင်မှုများကို ရရှိရန် ကျွန်ုပ်တို့ကို 1-877-626-9298 (TTY- 1-800-662-1220) သို့ 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, sèvis asistans lang gratis disponib pou ou. Èd 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 زبان دری صحبت می کنید، خدمات کمک زبان رایگان برای شما قابل دسترس است. کمک امدادی مناسب و خدمات برای دسترسی به معلومات در فرمت میسر بصورت مجانی ارائه می‌شود. برای دسترسی به این خدامت، با این شماره ها تماس حاصل کنید 1-877-626-9298 (TTY: 1-800-662-1220).

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