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?	Medical: In-Network: $1,000 Individual/ $2,000 Family; Out-of-Network: $2,000 Individual/ $4,000 Family Pharmacy: $1,250 per person	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
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?	Medical: In-Network: $8,000 Individual/$14,000 Family; Out-of-Network: $12,000 Individual/ $24,000 Family Pharmacy: $2,650 Individual/$5,300 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Costs for penalties for failure to obtain preauthorization for services, 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	$50 Copay/visit Deductible does not apply	40% Coinsurance	None 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	$70 Copay/visit Deductible does not apply	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: Not Covered Adult Immunizations: Not Covered Well Child Visit: 40% Coinsurance	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 year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: $70 Copay/visit X-Ray: Deductible does not apply Blood Work: No Charge Blood Work: Deductible does not apply	X-Ray: 40% Coinsurance Blood Work: 40% Coinsurance	None 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	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.OptumRx.com	Tier 1 (Generic drugs)	Retail 30-day supply: $30 Retail 30-day supply 4th fill and after: $75 Retail or OptumRx Mail Order 90-day supply: $75	Not Covered	Pharmacy Benefit Administered by OptumRx: 1-855-209-1300. Rx deductible of $1,250 per person applies. Copayments apply after the Rx deductible has been met. Certain breast cancer risk reducing medications in certain cases, smoking cessation medications for those over 18 for certain duration at no charge and for women, generic oral contraceptives are covered with a copay of $0. Specialty drugs must be filled by a Designated Pharmacy.
	Tier 2 (Preferred brand drugs)	Retail 30-day supply: $80 Retail 30-day supply 4th fill and after: $200 Retail or OptumRx Mail Order 90-day supply: $200	Not Covered	
	Tier 3 (Non-preferred brand drugs)	Retail 30-day supply: $150 Retail 30-day supply 4th fill and after: $375 Retail or OptumRx Mail Order 90-day supply: $375	Not Covered	

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None 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	

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 immediate medical attention	Emergency room care	$200 Copay/visit Deductible does not apply	$200 Copay/visit Deductible does not apply	None 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	No Charge Deductible does not apply	No Charge Deductible does not apply	None 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	$75 Copay/visit Deductible does not apply	40% Coinsurance	None 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 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	$70 Copay/visit Deductible does not apply	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.

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

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)	
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	No Charge Deductible does not apply	40% Coinsurance	None
	Rehabilitation services	$70 Copay/visit Deductible does not apply	40% Coinsurance	45 Visits per year limit. The visit limit does not apply to Rehabilitation Services for a mental health condition or substance use disorder.
	Habilitation services	$70 Copay/visit Deductible does not apply	40% Coinsurance	45 Visits per 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 Deductible does not apply	40% Coinsurance	None
	Hospice services	No Charge Deductible does not apply	40% Coinsurance	Family bereavement counseling limited to 5 Visits per year
If your child needs dental or eye care	Children's eye exam	$70 Copay/visit Deductible does not apply	Not Covered	1 Exam per calendar 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
- Prescription Drugs
- Private-duty nursing
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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

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.

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	$1,000
Specialist copayment	$70
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	$1,000
Copayments	$140
Coinsurance	$2,010
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	**$3,180**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	$1,000
Specialist copayment	$70
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	$0
Copayments	$1,810
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	**$1,910**

Mia's Simple Fracture

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

The plan's overall deductible	$1,000
Specialist copayment	$70
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	$0
Copayments	$550
Coinsurance	$50
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$610**

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).

দৃ আকষণ : আপিন যিদ বাংলাতেও কথা বেলন, তাহেল িবনামূল্যে ভাষা সহায়তা পিরেষবা আপনার জন্য উপল । অ্যাে সেযাগ্য ফরম্যাট তথ্য দানের জন্য উপযু সহায়ক সাহায্য এবং পিরেষবা িল ও িবনামূল্যে উপল ়। এই পিরেষবা িল অ্যাে স করার জন্য, অনু হ কের আমাদর 1-877-626-9298 (TTY: 1-800-662-1220) ন ের কল ক ন।

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 दनुहोस्: तपाईं नेपाल बोल्नुहुन्छ भने, िनःशुल्क भाषा सहायता सेवाहरू तपाईंका लाि□ग उपलब्ध छन्। सुलभ ढाँचाहरूमा जानकार दान गनर् उपयुक्त सहायक सहायताहरू र सेवाहरू पिन

िनःशुल्क उपलब्ध छन्। यी सेवाहरू उपयाेग गनर्, कृपया हामीलाई 1-877-626-9298 (TTY: 1-800-662-1220) मा फोन गनुर्होस्।

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- နမ့ ကတိၤအဲကလံးကိျာဉ်နှဉ်, တ တိစၢၤမၤစၢၤကိျာဉ် တ မၤစၢၤတ မၤ အကလီအိဉ်လၢနဂီ လၢနမၤန့ အီၤသ့လီၤ. တ မၤစၢၤတ နှ ဟူပီးလီ ဒီး တ မၤစၢၤတ မၤ လၢအဘဉ်ဘျိုးဘဉ်ဒါတဖဉ် ကဟ့ဉ်လီၤ တ ဂ့ တ ကိျၤ လၢကိျၤကဲျလၢတ ုဉ်ာ်လီၤမၤန့ အီၤသ့တဖဉ် စ့ ကီး အိဉ်လၢနမၤန့ အီၤသ့ လၢတလိဉ်ဟ့ဉ်အပှၤဘဉ်နှဉ်လီၤ. လၢကမၤန့ တ မၤစၢၤတ မၤတဖဉ်အံၤအဂီ , ဝံသးစူၤ ကိးပှၤဖဲ
1-877-626-9298 (TTY: 1-800-662-1220).

သတိ ပရုန်- သင် ြမန်မာ ေြပာဆုိလ င် ဘာသာစကားအကူအညီ ဝန်ေဆာင်မများကုိ သင့်အတွက် အခမဲ့ရ ုိ ုိင်သည်။ မသန်စွမ်းသူများ အသုံး ပ ုိင်သည့် ေဖာမတ်များြဖင့် အချက်အလက်များ

ပံုိပုးေပးိ ုင်သည့် သင့်ေလျာ်ေသာ ေထာက်ကူပစည်းများ ှင့် ဝန်ေဆာင်မများကုိလည်း အခမဲ့ရ ုိင်ပါသည်။
ဤဝန်ေဆာင်မများကုိ ရ ှိရန် က ုိ်ပ်တုိ့ကုိ 1-877-626-9298 (TTY- 1-800-662-1220) သုိ့
ဖုန်းေခ ဆုိပါ။

CHÚ : Nếu qu vị nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho qu 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).