**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 Excellus BlueCross BlueShield at 1-800-493-0318/TTY: 800-662-1220 or the Plan Administrator at 1-315-443-4042. 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.excellusbcbs.com or call 1-800-493-0318/TTY: 800-662-1220 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For in-network providers: $150 individual/ $300 family. For out-of-network providers: $300 individual/ $1,000 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 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 is covered before you meet your deductible. | 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?** | For in-network providers $2,000 individual / $4,000 family. For out-of-network providers $6,000 individual / $12,000 family. There is a separate out-of-pocket limit on prescription drugs purchased through the prescription drug manager (PBM): $2,000 individual/ $4,000 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, 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?** | 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 an in-network provider?** | Yes. See www.excellusbcbs.com or call 1-800-493-0318/ TTY: 800-662-1220 for a list of in-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 in-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 | $35 copay/visit | $35 copay and 30% coinsurance/visit | None |
| | Specialist visit | $50 copay/visit | $50 copay and 30% coinsurance/visit | None |
| | Preventive care/screening/ immunization | Adult physical: No charge<br>Adult immunizations: No charge<br>Well child visit: No charge<br>Deductible does not apply | Generally, 30% 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.<br><br>Limited to one (1) routine physical exam per calendar year for members age 19 and older. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $50 copay/visit (x-rays)<br>No charge, deductible does not apply/test (blood work) | $50 copay and 30% coinsurance/visit (x-rays)<br>30% coinsurance/test (blood work) | There is no charge and the deductible does not apply to colonoscopies and preventive and diagnostic breast cancer screenings when rendered by an in-network provider. |
| | Imaging (CT/PET scans, MRIs) | $50 copay/visit | $50 copay and 30% coinsurance/visit | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at https://hr.syr.edu/benefits/health-benefits/prescription-drug-coverage | Tier 1 (Lower cost, generics and some brand name drugs) | 20% coinsurance (retail); $20 copay (mail order)/ prescription | Not covered | Limited to a 90-day supply (mail order) and 30-day supply (retail). Retail 90-day supply also allowed at retail coinsurance level when using a local participating pharmacy. Dispense as written (DAW) penalty may apply.<br><br>Specialty drugs are limited to a 30-day supply.<br><br>Prescription drugs to treat infertility are limited to $20,000 per lifetime. This limit is separate from the $20,000 lifetime limit for medical treatment of infertility. |
| | Tier 2 (Mid-range cost, preferred brand name drugs) | 25% coinsurance (retail); $50 copay (mail order)/ prescription | Not covered | |
| | Tier 3 (Higher cost, brand name and some generic drug) | 45% coinsurance (retail); $90 copay (mail order)/ prescription | Not covered | |
| | Tier 4 (Specialty drugs) | See the mail order copays above | 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) | $200 copay (hospital outpatient) or $150 copay (ambulatory surgery center)/visit | $200 copay and 30% coinsurance (hospital outpatient) or $150 copay and 30% coinsurance (ambulatory surgery center)/visit | None |
| | Physician/surgeon fees | No charge, deductible does not apply | 30% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $150 copay/visit | $150 copay/visit | Copay waived if admitted; however, will be subject to the inpatient copay listed below. |
| | Emergency medical transportation | $100 copay/trip | $100 copay/trip | None |
| | Urgent care | $50 copay/visit | $50 copay and 30% coinsurance/visit | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $350 copay | $350 copay and 30% coinsurance | None |
| | Physician/surgeon fees | No charge, deductible does not apply | 30% coinsurance | Physician care is limited to one (1) visit/day. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $35 copay/visit | $35 copay and 30% coinsurance/visit | None |
| | Inpatient services | $350 copay (facility)<br>No charge, deductible does not apply (physician) | $350 copay and 30% coinsurance (facility)<br>30% coinsurance (physician) | Physician care is limited to one (1) visit/day. |
| **If you are pregnant** | Office visits | No charge, deductible does not apply | 30% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | No charge, deductible does not apply | 30% coinsurance | |
| | Childbirth/delivery facility services | $350 copay (facility)<br>No charge, deductible does not apply (birthing center) | $350 copay and 30% coinsurance | |
| **If you need help recovering** | Home health care | No charge, deductible does | 30% coinsurance | None |

| 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) | |
| **or have other special health needs** | | not apply | | |
| | Rehabilitation services | $35 copay | $35 copay and 30% coinsurance | None |
| | Habilitation services | $35 copay | $35 copay and 30% coinsurance | |
| | Skilled nursing care | $350 copay | $350 copay and 30% coinsurance | Limited to 180 days per admission (or series of admissions not separated by 90 consecutive days). |
| | Durable medical equipment | 10% coinsurance | 40% coinsurance | None |
| | Hospice services | No charge, deductible does not apply | 30% coinsurance | None |
| **If your child needs dental or eye care** | Children's eye exam | $35 copay (PCP)/$50 copay (Specialist)/visit | $50 copay and 30% coinsurance | Limited to one (1) exam every 24 consecutive months. |
| | 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
- 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 (Limited to $750 (single) or $1,500 (binaural) every three (3) calendar years)
- Infertility treatment ($20,000 lifetime limit for medical and a separate $20,000 lifetime limit for prescription drugs)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult & Child)

**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: the

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthcarereform. 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 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: Excellus BlueCross BlueShield at 1-800-493-0318/TTY: 800-662-1220 or www.excellusbcbs.com; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthcarereform. Additionally, a consumer assistance program can help you file your appeal contact Community Service Society of New York, Community Health Advocates, 633 Third Avenue, 10th floor, New York, NY 10017, 1-800-614-5400, http://www.communityhealthadvocates.org (website) or cha@cssny.org (email). A list of states with Consumer Assistance Programs is available at: 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.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-493-0318.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-493-0318.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-493-0318.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-493-0318.

*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, contact the Plan Administrator at 315-443-4042 for a copy of the plan or policy document.

## 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** **$150**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$350**
- **Other coinsurance** **10%**

**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 | $150 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$710** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$150**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$350**
- **Other coinsurance** **10%**

**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 | $150 |
| Copayments | $300 |
| Coinsurance | $700 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,170** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$150**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$350**
- **Other coinsurance** **10%**

**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 | $150 |
| Copayments | $800 |
| Coinsurance | $30 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$980** |

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

## 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, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, 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, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 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, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.