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

<table>
<thead>
<tr>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>For in-network providers: $200 individual/ $400 family. For out-of-network providers: $300 individual/ $1,000 family</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care is covered before you meet your deductible.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>For in-network providers $1,500 individual / $3,000 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</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use an in-network provider?</strong></td>
<td>Yes. See <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a> or call 1-800-493-0318/TTY: 800-662-1220 for a list of in-network providers.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
</tr>
</tbody>
</table>
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>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% <strong>coinsurance</strong>/visit</td>
<td>30% <strong>coinsurance</strong>/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> visit</td>
<td>20% <strong>coinsurance</strong>/visit</td>
<td>30% <strong>coinsurance</strong>/visit</td>
<td>None</td>
</tr>
</tbody>
</table>
| | Preventive care/screening/immunization | Adult physical: No charge  
Adult immunizations: No charge  
Well child visit: No charge **Deductible** does not apply | 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.  
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) | 20% **coinsurance** | 30% **coinsurance** | 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) | 20% **coinsurance** | 30% **coinsurance** |  |
| If you need drugs to treat your illness or condition | Tier 1 (Lower cost, generics and some brand name drugs) | 15% **coinsurance** (retail); lesser of $15 **copay** or 15% **coinsurance** (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.  
**Specialty drugs** are limited to a 30-day supply.  
**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); lesser of $45 **copay** or 25% **coinsurance** (mail order)/prescription | Not covered |  |
| | Tier 3 (Higher cost, brand name and some generic drug) | 40% **coinsurance** (retail); lesser of $90 **copay** or 40% **coinsurance** (mail order)/prescription | Not covered |  |
| | Tier 4 (**Specialty drugs**) | See the mail order **copays** above | Not covered |  |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% **coinsurance** | 30% **coinsurance** | None |
| | Physician/surgeon fees | 20% **coinsurance** | 30% **coinsurance** | None |

* For more information about limitations and exceptions, contact the Plan Administrator at 315-443-4042 for a copy of the **plan** or policy document.
<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>If you need immediate medical attention</td>
<td><strong>Emergency room care</strong></td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 30% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>In-Network Provider (You will pay the least): 5% coinsurance</td>
<td>Out-of-Network Provider (You will pay the least): 5% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>In-Network Provider (You will pay the least): 5% coinsurance</td>
<td>Out-of-Network Provider (You will pay the least): 5% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the least): 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>In-Network Provider (You will pay the least): 5% coinsurance</td>
<td>Out-of-Network Provider (You will pay the least): 5% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge, deductible does not apply</td>
<td>Out-of-Network Provider (You will pay the least): 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge, deductible does not apply</td>
<td>Out-of-Network Provider (You will pay the least): 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>5% coinsurance</td>
<td>Out-of-Network Provider (You will pay the least): 5% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td><strong>Home health care</strong></td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the least): 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the least): 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the least): 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>In-Network Provider (You will pay the least): 5% coinsurance</td>
<td>Out-of-Network Provider (You will pay the least): 5% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>In-Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the least): 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>In-Network Provider (You will pay the least): 5% coinsurance</td>
<td>Out-of-Network Provider (You will pay the least): 5% coinsurance (inpatient) 5% coinsurance (outpatient)</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, contact the Plan Administrator at 315-443-4042 for a copy of the plan or policy document.
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<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>If your child needs dental or eye</td>
<td>Children’s eye exam</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>care</td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</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.)**

- 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)

* For more information about limitations and exceptions, contact the Plan Administrator at 315-443-4042 for a copy of the plan or policy document.
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.


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, kwijjigo holne’ 1-800-493-0318.

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**: $200
- **Specialist coinsurance**: 20%
- **Hospital (facility) coinsurance**: 5%
- **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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
</tr>
</thead>
</table>

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

- **Cost Sharing**
  - **Deductibles**: $200
  - **Copayments**: $0
  - **Coinsurance**: $700

  **What isn’t covered**
  - Limits or exclusions: $60

  **The total Peg would pay is**: $960

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

- **The plan's overall deductible**: $200
- **Specialist coinsurance**: 20%
- **Hospital (facility) coinsurance**: 5%
- **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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$5,600</th>
</tr>
</thead>
</table>

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

- **Cost Sharing**
  - **Deductibles**: $200
  - **Copayments**: $0
  - **Coinsurance**: $1,700

  **What isn’t covered**
  - Limits or exclusions: $20

  **The total Joe would pay is**: $1,520

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

- **The plan’s overall deductible**: $200
- **Specialist coinsurance**: 20%
- **Hospital (facility) coinsurance**: 5%
- **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)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$2,800</th>
</tr>
</thead>
</table>

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

- **Cost Sharing**
  - **Deductibles**: $200
  - **Copayments**: $0
  - **Coinsurance**: $500

  **What isn’t covered**
  - Limits or exclusions: $0

  **The total Mia would pay is**: $700

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)  
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 anvlopa 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.

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

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

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 amín.

Прощохь! Аν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωτερικά για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

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