



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.excellusbcbcs.com](http://www.excellusbcbcs.com) or call 1-800-493-0318/TTY: 800-662-1220 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">in-network providers</a> : \$200 individual/ \$400 family. For <a href="#">out-of-network providers</a> : \$300 individual/ \$1,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">in-network providers</a> \$2,000 individual / \$4,000 family. For <a href="#">out-of-network providers</a> \$6,000 individual / \$12,000 family. There is a separate <a href="#">out-of-pocket limit</a> on <a href="#">prescription drugs</a> purchased through the prescription drug manager (PBM): \$2,000 individual/ \$4,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use an <a href="#">in-network provider</a>?</b>	Yes. See <a href="http://www.excellusbcbcs.com">www.excellusbcbcs.com</a> or call 1-800-493-0318/ TTY: 800-662-1220 for a list of <a href="#">in-network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">in-network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$35 <a href="#">copay</a> /visit	\$35 <a href="#">copay</a> and 30% <a href="#">coinsurance</a> /visit	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit	\$50 <a href="#">copay</a> and 30% <a href="#">coinsurance</a> /visit	None
	<a href="#">Preventive care/screening/immunization</a>	Adult physical: No charge Adult immunizations: No charge Well child visit: No charge <a href="#">Deductible</a> does not apply	Generally, 30% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.  Limited to one (1) routine physical exam per calendar year for members age 19 and older.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 <a href="#">copay</a> /visit (x-rays) No charge, <a href="#">deductible</a> does not apply/test (blood work)	\$50 <a href="#">copay</a> and 30% <a href="#">coinsurance</a> /visit (x-rays) 30% <a href="#">coinsurance</a> /test (blood work)	There is no charge and the <a href="#">deductible</a> does not apply to colonoscopies and preventive and diagnostic breast cancer screenings when rendered by an <a href="#">in-network provider</a> .
	Imaging (CT/PET scans, MRIs)	\$50 <a href="#">copay</a> /visit	\$50 <a href="#">copay</a> and 30% <a href="#">coinsurance</a> /visit	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://hr.syr.edu/benefits/health-benefits/prescription-drug-coverage">https://hr.syr.edu/benefits/health-benefits/prescription-drug-coverage</a>	Tier 1 (Lower cost, generics and some brand name drugs)	20% <a href="#">coinsurance</a> (retail); \$20 <a href="#">copay</a> (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 <a href="#">coinsurance</a> level when using a local participating pharmacy. Dispense as written (DAW) penalty may apply.  <a href="#">Specialty drugs</a> are limited to a 30-day supply.  <a href="#">Prescription drugs</a> 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% <a href="#">coinsurance</a> (retail); \$50 <a href="#">copay</a> (mail order)/ prescription	Not covered	
	Tier 3 (Higher cost, brand name and some generic drug)	45% <a href="#">coinsurance</a> (retail); \$90 <a href="#">copay</a> (mail order)/ prescription	Not covered	
	Tier 4 ( <a href="#">Specialty drugs</a> )	See the mail order <a href="#">copays</a> above	Not covered	

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

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 <a href="#">copay</a> (hospital outpatient) or \$150 <a href="#">copay</a> (ambulatory surgery center)/visit	\$200 <a href="#">copay</a> and 30% <a href="#">coinsurance</a> (hospital outpatient) or \$150 <a href="#">copay</a> and 30% <a href="#">coinsurance</a> (ambulatory surgery center)/visit	None
	Physician/surgeon fees	No charge, <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /visit	\$150 <a href="#">copay</a> /visit	<a href="#">Copay</a> waived if admitted; however, will be subject to the inpatient <a href="#">copay</a> listed below.
	<a href="#">Emergency medical transportation</a>	\$100 <a href="#">copay</a> /trip	\$100 <a href="#">copay</a> /trip	None
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	\$50 <a href="#">copay</a> and 30% <a href="#">coinsurance</a> /visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 <a href="#">copay</a>	\$350 <a href="#">copay</a> and 30% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	No charge, <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	Physician care is limited to one (1) visit/day.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <a href="#">copay</a> /visit	\$35 <a href="#">copay</a> and 30% <a href="#">coinsurance</a> /visit	None
	Inpatient services	\$350 <a href="#">copay</a> (facility) No charge, <a href="#">deductible</a> does not apply (physician)	\$350 <a href="#">copay</a> and 30% <a href="#">coinsurance</a> (facility) 30% <a href="#">coinsurance</a> (physician)	Physician care is limited to one (1) visit/day.
If you are pregnant	Office visits	No charge, <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copay</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge, <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$350 <a href="#">copay</a> (facility) No charge, <a href="#">deductible</a> does not apply (birthing center)	\$350 <a href="#">copay</a> and 30% <a href="#">coinsurance</a>	

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge, <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
	<a href="#">Rehabilitation services</a>	\$35 <a href="#">copay</a>	\$35 <a href="#">copay</a> and 30% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	\$35 <a href="#">copay</a>	\$35 <a href="#">copay</a> and 30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	\$350 <a href="#">copay</a>	\$350 <a href="#">copay</a> and 30% <a href="#">coinsurance</a>	Limited to 180 days per admission (or series of admissions not separated by 90 consecutive days).
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	No charge, <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
<b>If your child needs dental or eye care</b>	Children's eye exam	\$35 <a href="#">copay</a> (PCP)/\$50 <a href="#">copay</a> (Specialist)/visit	\$50 <a href="#">copay</a> and 30% <a href="#">coinsurance</a>	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 <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](http://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.excellusbcbbs.com](http://www.excellusbcbbs.com); the 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>. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Community Service Society of New York, Community Health Advocates, 633 Third Avenue, 10<sup>th</sup> floor, New York, NY 10017, 1-800-614-5400, <http://www.communityhealthadvocates.org> (website) or [cha@cssny.org](mailto:cha@cssny.org) (email). 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 <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, kwijigo 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 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$660</b>

### 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 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$200
- [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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,030</b>

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: 1-315-671-6656

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, 1-800-537-7697 (TDD)  
Complaint forms are available at <https://www.hhs.gov/regulations/complaints-and-appeals/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 anvlop 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.