### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-Network: $275 Individual/$550 Two Person/$825 Family; Out-of-Network: $1,100 Individual/$2,200 Two Person/$2,750 Family</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes, Preventive Care</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>In-Network: $1,800 Individual/$3,600 Two Person/$5,300 Family; Out-of-Network: $3,550 Individual/$7,100 Two Person/$8,800 Family</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Costs for penalties for failure to obtain preauthorization for services, premiums, balance billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a> or call 1-800-499-1275 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
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</table>
**Common Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information**
--- | --- | --- | ---
**If you visit a health care provider’s office or clinic** | | |
**Primary care visit to treat an injury or illness** | **Primary care visit to treat an injury or illness** | In-Network Provider (You will pay the least): $25 Copay/visit Deductible does not apply | Out-of-Network Provider (You will pay the most): 30% Coinsurance

Specialist visit | **Specialist visit** | In-Network Provider (You will pay the least): $40 Copay/visit Deductible does not apply | Out-of-Network Provider (You will pay the most): 30% Coinsurance

Preventive care/screening/immunization | **Preventive care/screening/immunization** | Adult Physical: No Charge Deductible does not apply | Adult Physical: 30% Coinsurance Deductible does not apply

**If you have a test** | | |
**Diagnostic test (x-ray, blood work)** | **Diagnostic test (x-ray, blood work)** | X-Ray: $40 Copay/visit Deductible does not apply Blood Work: No Charge Deductible does not apply | Preauthorization Required. If you don’t get a preauthorization, benefits will be reduced by 50% of Coinsurance up to $500.

Imaging (CT/PET scans, MRIs) | **Imaging (CT/PET scans, MRIs)** | $40 Copay/visit Deductible does not apply | 30% Coinsurance

**If you need drugs to treat your illness or condition** | | |
More information about *prescription drug coverage* is available at optumrx.com | **Tier 1 (Generic drugs)** | 10% Coinsurance | Not Covered

**Tier 2 (Preferred brand drugs)** | 30% Coinsurance | Not Covered

**Tier 3 (Non-preferred brand drugs)** | 30% Coinsurance | Not Covered

**If you have outpatient surgery** | | |
Facility fee (e.g., ambulatory surgery center) | **Facility fee (e.g., ambulatory surgery center)** | 10% Coinsurance | 30% Coinsurance

Physician/surgeon fees | **Physician/surgeon fees** | 10% Coinsurance | 30% Coinsurance

**If you need immediate medical attention** | | |
Emergency room care | **Emergency room care** | $200 Copay/visit Deductible does not apply | Not Covered

Emergency medical transportation | **Emergency medical transportation** | $200 Copay/visit Deductible does not apply | Not Covered

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* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com
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<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>$25 Copay/visit Deductible does not apply</td>
<td>30% Coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>
| Facility fee (e.g., hospital room)        | 10% Coinsurance                                           | 30% Coinsurance                                        | Preauthorization Required for out-of-network services only.  
If you don't get a preauthorization, benefits will be reduced by 50% of Coinsurance up to $500. However, Preauthorization is Not Required for Emergency Admissions |
| Physician/surgeon fees                    | 10% Coinsurance                                           | 30% Coinsurance                                        | None                                                   |
| If you have a hospital stay               | Outpatient services $25 Copay/visit Deductible does not apply | 30% Coinsurance                                        |                                                        |
| Inpatient services                        | 10% Coinsurance                                           | 30% Coinsurance                                        |                                                        |
| If you need mental health, behavioral health, or substance abuse services | Office visits No Charge                                   | 30% Coinsurance                                        | Cost sharing does not apply for preventive services.   |
| If you are pregnant                       | Childbirth/delivery professional services 10% Coinsurance | 30% 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     | 10% Coinsurance                                           | 30% Coinsurance                                        |                                                        |
| If you need help recovering or have other special health needs | Home health care 10% Coinsurance                           | 25% Coinsurance                                        | Deductible is limited to $50                               |
|                                           | Rehabilitation services $25 Copay/visit Deductible does not apply | 30% Coinsurance                                        | Preauthorization Required. If you don't get a preauthorization, benefits will be reduced by 50% of Coinsurance up to $500 |
|                                           | Habilitation services $25 Copay/visit Deductible does not apply | 30% Coinsurance                                        | 45 Visits per year limit                               |
|                                           | Skilled nursing care 10% Coinsurance                      | 30% Coinsurance                                        | 45 Visits per year limit                               |
|                                           | Durable medical equipment 20% Coinsurance Deductible does not apply | 30% Coinsurance                                        | 60 Days per year limit Preauthorization Required Out-of-Network services only. If you don't get a preauthorization, benefits will be reduced by 50% of Coinsurance up to $500 |
|                                           | Hospice services No Charge Deductible does not apply      | 30% Coinsurance                                        | None                                                   |

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

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<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
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<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</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.)**

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

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

### 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 www.dol.gov/ebsa/healthreform. 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/ebsa/healthreform; 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: www.dol.gov/ebsa/healthreform 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: $275
- Specialist copayment: $40
- Hospital (facility) coinsurance: 10%
- 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:
- Deductibles: $280
- Copayments: $80
- Coinsurance: $1,080
- What isn’t covered: $70

The total Peg would pay is **$1,510**

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

- The plan’s overall deductible: $275
- Specialist copayment: $40
- Hospital (facility) coinsurance: 10%
- 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:
- Deductibles: $0
- Copayments: $1,120
- Coinsurance: $0
- What isn’t covered: $100

The total Joe would pay is **$1,220**

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

- The plan’s overall deductible: $275
- Specialist copayment: $40
- Hospital (facility) coinsurance: 10%
- 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:
- Deductibles: $0
- Copayments: $560
- Coinsurance: $50
- What isn’t covered: $10

The total Mia would pay is **$620**

The plan would be responsible for the other costs of these EXAMPLE covered services.
Complaint forms are available at http://www hhsgov/acr/offices/field/lnq/exclmnlr
1-800-368-1094, 800-537-7697 (TDD)
Washington, D.C. 20210
Room 509F, HH Building
200 Independence Avenue, SW
U.S. Department of Health and Human Services

You can also file a Civil Rights complaint with the U.S. Department of Health and Human Services.

Health Plans Civil Rights Coordinator is available to help you.

You can file a grievance in person or by mail or phone. If you need help filing a grievance, the
Fax: 315-671-6566
TTY number: 1-800-421-2222
Telephone number: 1-800-614-6575
Syracuse, NY 13222
P.O. Box 4717
Attention: Civil Rights Coordinator
Advocate Department

Grievance with:

another way on the basis of race, color, national origin, age, disability, or sex, you can file a
If you believe that the Health Plan has failed to provide these services or discriminated in

If you need these services, please refer to the enclosed document for ways to reach us.

• Information written in other languages

• Qualified interpreters

• Provides free language services to people whose primary language is not English, such as:

• Written information in other formats (large print, audio, accessible electronic

• Qualified sign language interpreters

• Provides free aids and services to people with disabilities to communicate effectively

The Health Plan:

treat them differently because of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or
Our Health Plan complies with federal Civil Rights Laws. We do not discriminate on the basis of

Notice of Nondiscrimination