




**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [excellusbcbs.com](http://excellusbcbs.com) or by calling 1-800-499-1275.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	<p>\$0 Individual /                      \$0 Family, In Network                      \$500 Individual /                      \$1500 Family, Out of network                      Does not apply to Preventive Care.</p>	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>	Yes, \$1500 Individual / \$4500 Family, Out of network	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a <u>network of providers</u>?</b>	Yes. See <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a> or call 1-800-499-1275 for a list of participating providers.	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a <u>specialist</u>?</b>	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page [4 or 5]. See your policy or plan document for additional information about <b>excluded services</b> .

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the glossary at

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
-  The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	Adult \$15 co-pay Child No Charge	20% co-insurance	Child up to age 19
	Specialist visit	\$25 co-pay	\$25 co-pay	-----none-----
	Other practitioner office visit	\$25 co-pay	Acupuncture 20% co-insurance Chiropractic 20% co-insurance	Acupuncture 10 Visit(s) per year
	Preventive care/screening/immunization	No Charge	Adult Physical 20% co-insurance Well Child No Charge Adult Immunizations 20% co-insurance	Adult Physical 1 Visit(s) per year
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	X-Ray \$25 co-pay Lab Services No Charge	20% co-insurance	-----none-----
	Imaging (CT/PET scans, MRIs)	\$25 co-pay	20% co-insurance	-----none-----

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b> <b>More information about <u>prescription drug coverage</u> is available at <a href="http://excellusbcb.com">excellusbcb.com</a></b>	Generic drugs	Child copay No Charge Retail Prescription \$5 co-pay Mail Order Prescription \$5 co-pay	Not Covered	Child copay up to age 19
	Preferred brand drugs	Retail Prescription \$25 co-pay Mail Order Prescription \$25 co-pay	Not Covered	-----none-----
	Non-preferred brand drugs	Retail Prescription \$50 co-pay Mail Order Prescription \$50 co-pay	Not Covered	-----none-----
	Specialty drugs	Retail Prescription \$50 co-pay Mail Order Prescription \$50 co-pay	Not Covered	-----none-----
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$75 co-pay	20% co-insurance	-----none-----
	Physician/surgeon fees	No Charge	20% co-insurance	-----none-----
<b>If you need immediate medical attention</b>	Emergency room services	\$75 co-pay	\$75 co-pay	-----none-----
	Emergency medical transportation	\$75 co-pay	\$75 co-pay	-----none-----
	Urgent care	\$25 co-pay	20% co-insurance	-----none-----

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$150 co-pay	20% co-insurance	-----none-----
	Physician/surgeon fee	No Charge	20% co-insurance	-----none-----
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$25 co-pay	20% co-insurance	-----none-----
	Mental/Behavioral health inpatient services	\$150 co-pay	20% co-insurance	-----none-----
	Substance use disorder outpatient services	\$25 co-pay	20% co-insurance	-----none-----
	Substance use disorder inpatient services	\$150 co-pay	20% co-insurance	-----none-----
<b>If you are pregnant</b>	Prenatal and postnatal care	No Charge	20% co-insurance	-----none-----
	Delivery and all inpatient services	No Charge	Physician 20% co-insurance Facility 20% co-insurance Anesthesia No Charge	-----none-----
<b>If you need help recovering or have other special health needs</b>	Home health care	No Charge	20% co-insurance	40 Visit(s) per year
	Rehabilitation services	Outpatient \$25 co-pay Inpatient \$150 co-pay	20% co-insurance	Outpatient 45 Visit(s) per year Inpatient 60 Day(s) per year
	Habilitation services	\$25 co-pay	20% co-insurance	45 Visit(s) per year
	Skilled nursing care	\$150 co-pay	20% co-insurance	45 Day(s) per year
	Durable medical equipment	20% co-insurance	20% co-insurance	-----none-----
	Hospice service	No Charge	20% co-insurance	-----none-----
<b>If your child needs dental or eye care</b>	Eye exam	\$25 co-pay	20% co-insurance	1 Visit(s) per year
	Glasses	\$60 Allowance	\$60 Allowance	Every 1 Year(s)
	Dental check-up	Not Covered	Not Covered	-----none-----

## Excluded Services & Other Covered Services:

### Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental Care (Adult)
- Long term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

### Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-499-1275. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Customer Service at 1-800-499-1275.

- For group health coverage subject to ERISA, you can contact your plan at 1-800-499-1275. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). If coverage is insured, you can contact New York State Department of Financial Services at 1-800-342-3736
- For non-federal governmental group health plans and church plans that are group health plans, call 1-800-499-1275. If coverage is insured, you can contact New York State Department of Financial Services at 1-800-342-3736
- Additionally, a consumer assistance program can help you file your appeal. Contact Community Health Advocates, the State's consumer assistance program, at 1-888-614-5400 or at [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org).

## Language Access Services:

Español: Para obtener asistencia en Español, llame al 1-800-499-1275.

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-499-1275.

中文: 如果需要中文的帮助, 请拨打这个号码 1-800-499-1275.

Dine: Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-499-1275.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$7,360
- Patient pays: \$180

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$30
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$180</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$4,200
- Patient pays: \$1,200

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$1,160
Coinsurance	\$0
Limits or exclusions	\$40
<b>Total</b>	<b>\$1,200</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

**✗ No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

**✗ No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

**✓ Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

**✓ Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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