### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Out-of-Network: $250 Individual/$500 Two Person/$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>Are there services covered before you meet your deductible?</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>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$6,350 Individual/$12,700 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>What is not included in the out-of-pocket limit?</td>
<td>Costs for 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>Will you pay less if you use a network provider?</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>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</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>Copay</strong>/visit</td>
<td>20% <strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25 <strong>Copay</strong>/visit</td>
<td>20% <strong>Coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>Adult Physical: No Charge</td>
<td>Adult Physical: 20% <strong>Coinsurance</strong></td>
<td>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. 1 Exam per year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult Immunizations: No Charge</td>
<td>Adult Immunizations: 20% <strong>Coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Well Child Visit: No Charge</td>
<td>Well Child Visit: No Charge</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>X-Ray: No Charge</td>
<td>X-Ray: 20% <strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood Work: No Charge</td>
<td>Blood Work: No Charge does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No Charge</td>
<td>20% <strong>Coinsurance</strong></td>
<td>Preauthorization Required. If you don’t get a preauthorization, benefits will be reduced by Does Not Apply.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a></td>
<td>Tier 1 (Generic drugs)</td>
<td>$5/prescription retail, $10/prescription mail order</td>
<td>Not Covered</td>
<td>Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription) Preauthorization required. If you don’t get a preauthorization, you must pay the entire cost and submit a claim to us for reimbursement.</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred brand drugs)</td>
<td>$35/prescription retail, $70/prescription mail order</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-preferred brand drugs)</td>
<td>$70/prescription retail, $140/prescription mail order</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No Charge</td>
<td>20% <strong>Coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>20% <strong>Coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100 <strong>Copay</strong>/visit</td>
<td>$100 <strong>Copay</strong>/visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$50 <strong>Copay</strong>/visit</td>
<td>$50 <strong>Copay</strong>/visit <strong>Deductible</strong> does not apply</td>
<td>None</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com
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<tr>
<td><strong>Urgent care</strong></td>
<td></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Facility fee (e.g., hospital room)</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Physician/surgeon fees</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Outpatient services</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Inpatient services</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Office visits</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Childbirth/delivery professional services</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Childbirth/delivery facility services</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Home health care</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><strong>Deductible</strong> is limited to $50 Out-of-Network</td>
</tr>
<tr>
<td><strong>Rehabilitation services</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Habilitation services</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Skilled nursing care</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Hospice services</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>Family bereavement counseling limited to 5 Visits per year</td>
</tr>
<tr>
<td><strong>Children’s eye exam</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Children’s glasses</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td>None</td>
</tr>
<tr>
<td><strong>Children’s dental check-up</strong></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></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.)

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

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com
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
- 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
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.----------------------------------------

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

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### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible** $0
- **Specialist copayment** $25
- **Hospital (facility) copayment** $0
- **Other copayment** $0

**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** $0

- **In this example, Peg would pay:**
  - **Cost Sharing**
    - Deductibles
    - Copayments
    - Coinsurance
  - **What isn’t covered**
  - Limits or exclusions

- **The total Peg would pay is**

---

### Managing Joe’s type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible** $0
- **Specialist copayment** $25
- **Hospital (facility) copayment** $0
- **Other copayment** $0

**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** $0

- **In this example, Joe would pay:**
  - **Cost Sharing**
    - Deductibles
    - Copayments
    - Coinsurance
  - **What isn’t covered**
  - Limits or exclusions

- **The total Joe would pay is** $190

---

### Mia’s Simple Fracture

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

- **The plan’s overall deductible** $0
- **Specialist copayment** $25
- **Hospital (facility) copayment** $0
- **Other copayment** $0

**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** $0

- **In this example, Mia would pay:**
  - **Cost Sharing**
    - Deductibles
    - Copayments
    - Coinsurance
  - **What isn’t covered**
  - Limits or exclusions

- **The total Mia would pay is**

---

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.
Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html.
1-800-368-1099, 800-537-7697 (TDD)
Washington, D.C. 20201
Room 232F, HHF 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, 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:

Fax: 312-410-5656
TTY number: 1-800-410-2222
Telephone number: 1-800-634-6575

Syracuse, NY 13212
Room 417
Attn: Civil Rights Coordinator
Advocacy Division

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

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

- Information written in other languages
- Qualified interpreters
- Forms, other formats
- 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:

not treat them differently because of race, color, national origin, age, disability, or sex. 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.

Notice of Nondiscrimination