## Important Questions | Answers | Why This Matters:

### What is the overall deductible?
- **In-Network:** $250 Individual/$500 Two Person/$750 Family; **Out-of-Network:** $750 Individual/$1,500 Two Person/$2,250 Family
- 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.

### Are there services covered before you meet your deductible?
- Yes, **Preventive Care**
- 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 [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

### Are there other deductibles for specific services?
- **No**
- You don’t have to meet deductibles for specific services.

### What is the out-of-pocket limit for this plan?
- **In-Network:** $4,600 Individual/$6,900 Two Person/$9,200 Family; **Out-of-Network:** $1,750 Individual/$3,500 Two Person/$5,250 Family
- 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.

### What is not included in the out-of-pocket limit?
- Costs for penalties for failure to obtain preauthorization for services, premiums, balance billing charges, and health care this plan doesn’t cover.
- Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

### Will you pay less if you use a network provider?
- Yes. See [www.excellusbcbs.com](http://www.excellusbcbs.com) or call 1-800-499-1275 for a list of network providers.
- 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.

### Do you need a referral to see a specialist?
- **No**
- You can see the specialist you choose without a referral.
### Common Medical Event

#### If you visit a health care provider’s office or clinic

**Primary care visit to treat an injury or illness**
- In-Network Provider: $20 Copay/visit
- Out-of-Network Provider: $40 Copay/visit
- Deductible does not apply
- Coinsurance: 30%

**Specialist visit**
- In-Network Provider: $20 Copay/visit
- Out-of-Network Provider: $40 Copay/visit
- Deductible does not apply
- Coinsurance: 30%

**Preventive care/screening/immunization**
- Adult Physical: No Charge
- Adult Immunizations: No Charge
- Well Child Visit: No Charge
- Deductible does not apply
- Coinsurance: 30%

**In-Network Provider**
- You will pay the least
**Out-of-Network Provider**
- You will pay the most
**Limitations, Exceptions, & Other Important Information**
- None

#### If you have a test

**Diagnostic test** (x-ray, blood work)
- X-Ray: No Charge
- Blood Work: No Charge
- X-Ray: 30% Coinsurance
- Blood Work: 30% Coinsurance

**Imaging** (CT/PET scans, MRIs)
- No Charge
- 30% Coinsurance

**Limitations, Exceptions, & Other Important Information**
- Preauthorization Required. If you don’t get a preauthorization, benefits will be reduced by 50% of Coinsurance up to $500.

#### If you need drugs to treat your illness or condition

**More information about prescription drug coverage is available at www.excellusbcbs.com**

**Tier 1 (Generic drugs)**
- $10/prescription retail, $30/prescription mail order
- Deductible does not apply
- Not Covered

**Tier 2 (Preferred brand drugs)**
- $30/prescription retail, $90/prescription mail order
- Deductible does not apply
- Not Covered

**Tier 3 (Non-preferred brand drugs)**
- $50/prescription retail, $150/prescription mail order
- Deductible does not apply
- Not Covered

**Specialty drugs**
- $50/prescription retail
- Deductible does not apply
- Not Covered

**Limitations, Exceptions, & Other Important Information**
- 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.
- Specialty prescriptions must be filled by a participating Specialty Pharmacy. Specialty drugs are not eligible for mail order.
<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><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td><em>Emergency room care</em></td>
<td>$100 Copay/visit Deductible does not apply</td>
<td>$100 Copay/visit Deductible does not apply</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td><em>Emergency medical transportation</em></td>
<td>$40 Copay/visit Deductible does not apply</td>
<td>$40 Copay/visit Deductible does not apply</td>
</tr>
<tr>
<td></td>
<td><em>Urgent care</em></td>
<td>$40 Copay/visit Deductible does not apply</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250 Copay Deductible does not apply</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$40 Copay/visit Deductible does not apply</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$250 Copay Deductible does not apply</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$250 Copay Deductible does not apply</td>
<td>30% Coinsurance</td>
</tr>
</tbody>
</table>

* 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</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></td>
<td>Home health care</td>
<td>No Charge</td>
<td>25% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>No Charge</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$250 Copay Deductible does not apply</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% Coinsurance Deductible does not apply</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No Charge Deductible does not apply</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>$40 Copay/visit Deductible does not apply</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td></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)
- Hearing aids
- Long-term care
- Private-duty nursing
- Weight loss programs
- Chiropractic care

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

- Acupuncture
- Bariatric surgery

* For more information about limitations and exceptions, see plan or policy document at [www.excellusbcbs.com](http://www.excellusbcbs.com)
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 grievance for any reason to your plan. For more information about your rights, 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.
"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."

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(9 months of in-network pre-natal care and a hospital delivery)</strong></td>
<td><strong>(a year of routine in-network care of a well-controlled condition)</strong></td>
<td><strong>(in-network emergency room visit and follow up care)</strong></td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

**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)*

**Peg is Having a Baby**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>$60</td>
</tr>
</tbody>
</table>

**In this example, Peg would pay:**
The total Peg would pay is **$310**

**Managing Joe’s type 2 Diabetes**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$130</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,190</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>$60</td>
</tr>
</tbody>
</table>

**In this example, Joe would pay:**
The total Joe would pay is **$1,380**

**Mia’s Simple Fracture**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Total Example Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$180</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$40</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>$0</td>
</tr>
</tbody>
</table>

**In this example, Mia would pay:**
The total Mia would pay is **$470**

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/privacy.html.
1-800-368-1094, 800-537-7697 (TDD)
Washington, D.C. 20201
Room 233F, HHB 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.

You can file a grievance in person or by mail or phone at:

Fax: 315-671-6656
Tty number: 1-800-477-6656
Telephone number: 1-800-614-6575
Syracuse, NY 13222
Attn: Civil Rights Coordinator
Advocacy Department

Grievance with:

If you believe that the 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

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

- Information written in other languages
- Qualified interpreters
- Free aids and services to people whose primary language is not English, such as
  - Tapes, other formats
  - Written information in other formats (large print, audio, accessible electronic)
  - Qualified sign language interpreters
  - With us, such as:

The Health Plan:

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