




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 1-800-499-1275 or visit our website at [www.excellusbcbs.com](http://www.excellusbcbs.com). 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.cciio.cms.gov](http://www.cciio.cms.gov) or <https://www.healthcare.gov/sbc-glossary> or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	Effective 1/1/2027 Out-of-network: \$250 Individual/ \$500 2-Person/\$750 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 plan, 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, <a href="#">Preventive Care</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> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-Network: \$3,000 Individual/ \$6,000 2-person/ \$9,000 Family; Out-of-Network: \$3,300 Individual/ \$6,600 2-person/ \$9,900 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Costs for <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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a> or call 1-800-499-1275 for a list <a href="#">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 a <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="#">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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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. Deductible does not apply when there is a copayment

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 provider's office or clinic</b>	Primary care visit to treat an injury or illness	No charge	No charge	Effective 1/1/2027 In-Network <a href="#">copay</a> will be \$30 per visit and 20% <a href="#">coinsurance</a> for Out-of-Network after <a href="#">deductible</a> is met.
	<a href="#">Specialist</a> visit	No charge	No charge	Effective 1/1/2027 In-Network <a href="#">copay</a> will be \$35 per visit and 20% <a href="#">coinsurance</a> for Out-of-Network after <a href="#">deductible</a> is met.
	<a href="#">Preventive care/screening/immunization</a>	Adult physical: No charge Adult Immunizations: No charge Well Child visit: No charge	Adult physical: No charge Adult Immunizations: No charge Well Child visit: No charge	Effective 1/1/2027 Out-of-Network will be 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met. 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 one (1) exam per calendar year.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: No charge Blood work: No charge	X-ray: No charge Blood work: No charge	Effective 1/1/2027 Out-of-Network will be 20% <a href="#">coinsurance</a> after deductible is met. Out-of-Network Blood work will remain at No charge.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Imaging: Prior authorization is required. Effective 1/1/2027 Out-of-Network will be 20% <a href="#">coinsurance</a> after deductible is met.
<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="http://www.excellusbcb.com/rxlist">www.excellusbcb.com/rxlist</a>	Generic drugs (Tier 1)	\$5/prescription retail, \$10/prescription mail order	Not covered	<a href="#">Deductible</a> does not apply to In-Network <a href="#">copay</a> . Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). Prior authorization is required for certain <a href="#">prescription drugs</a> . <a href="#">Specialty drugs</a> must be filled by a designated pharmacy. <a href="#">Specialty drugs</a> are limited to a 30-day supply per fill and are not eligible for mail order.
	Preferred brand drugs (Tier 2)	\$35/prescription retail, \$70/prescription mail order	Not covered	
	Non-preferred brand drugs (Tier 3) <a href="#">Specialty drugs</a>	\$70/prescription retail, \$140/prescription mail order	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.excellusbcb.com](http://www.excellusbcb.com).

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)	No charge	No charge	Effective 1/1/2027 Out-of-Network will be 20% <a href="#">coinsurance</a> after deductible is met.
	Physician/surgeon fees	No charge	No charge	Effective 1/1/2027 Out-of-Network will be 20% <a href="#">coinsurance</a> after deductible is met.
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="#">Deductible</a> does not apply to In-Network or Out-of-Network <a href="#">copay</a> .
	<a href="#">Emergency medical transportation</a>	\$50 <a href="#">copay</a> /visit	\$50 <a href="#">copay</a> /visit	<a href="#">Deductible</a> does not apply to In-Network or Out-of-Network <a href="#">copay</a> .
	<a href="#">Urgent care</a>	No charge	No charge	Effective 1/1/2027 In-Network <a href="#">copay</a> will be \$35 per visit and 20% <a href="#">coinsurance</a> for Out-of-Network after <a href="#">deductible</a> is met.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Prior authorization is required. Effective 1/1/2027 In-Network <a href="#">copay</a> will be \$100 per stay. Out-of-Network will be 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met.
	Physician/surgeon fees	No charge	No charge	Prior authorization is required. Effective 1/1/2027 Out-of-Network will be 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	Effective 1/1/2027 In-Network <a href="#">copay</a> will be \$30 per visit for Outpatient services and \$100 for Inpatient per stay. Out-of-Network will be 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met.
	Inpatient services	No charge	No charge	
If you are pregnant	Office visits	No charge	No charge	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .
	Childbirth/delivery professional services	No charge	No charge	Effective 1/1/2027 Out-of-Network will be 20% <a href="#">coinsurance</a> after deductible is met.
	Childbirth/delivery facility services	No charge	No charge	Effective 1/1/2027 In-Network <a href="#">copay</a> will be \$100 per stay for Childbirth/delivery facility services. <a href="#">Deductible</a> does not apply to In-Network <a href="#">copay</a> .

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.excellusbcb.com](http://www.excellusbcb.com).

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 need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	No charge	Effective 1/1/2027 Out-of-Network will be 20% coinsurance after deductible is met. <a href="#">Deductible</a> is limited to \$50 Out-of-Network
	<a href="#">Rehabilitation services</a>	No charge	No charge	Effective 1/1/2027 In-Network copay will be \$35 per visit. Out-of-Network will be 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met. This applies to both Rehabilitation and Habilitation services.
	<a href="#">Habilitation services</a>	No charge	No charge	
	<a href="#">Skilled nursing care</a>	No charge	No charge	Effective 1/1/2027 Out-of-Network will be 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met.
	<a href="#">Durable medical equipment</a>	No charge	No charge	Effective 1/1/2027 Out-of-Network will be 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met.
	<a href="#">Hospice services</a>	No charge	No charge	Family bereavement counseling limited to 5 Visits per year. Effective 1/1/2027 Out-of-Network will be 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> is met.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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](#).)**

- |                                                                                                                                    |                                                                                                                                                                |                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Child)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Long-term care</li> <li>• Private duty nursing</li> <li>• Routine eye care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Child)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |                                                                                              |                                                                                                        |                                                                                                        |
|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> |
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\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.excellusbcb.com](http://www.excellusbcb.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, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov.ebsa/healthreform](http://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](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: the phone number on Your ID card or [www.excellusbcbcs.com](http://www.excellusbcbcs.com), the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. You may also contact the New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or [www.dfs.ny.gov](http://www.dfs.ny.gov). Additionally, a consumer assistance program can help you file your [appeal](#). Contact Community Service Society of New York, Community Health Advocates, 633 Third Avenue, 10th floor, New York, NY 10017, (888) 614-5400, <http://www.communityhealthadvocates.org/> (website), [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](#).

*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](#) \$0
- [Specialist copayment\\*](#) \$0
- 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*)

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

\* Specialist copay increases to \$35 effective 1/1/27

### 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\\*](#) \$0
- 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*)

<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>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$20</b>

\* Specialist copay increases to \$35 effective 1/1/27

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment\\*](#) \$0
- 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*)

<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>	\$0
<a href="#">Copayments</a>	\$150
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$150</b>

\* Specialist copay increases to \$35 effective 1/1/27

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: 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, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/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, contámos 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 anviyòr 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 saperne come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אדיש, איך אומזיסטע שפראך הילף אונערלעבל פאר אייך ביטע רעפערירט צום בייגלעייגטן דאקומענט צו זען אופנים זיך צו פארבריינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংস্কৃত 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 مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalalip 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. Drejtojuini dokumentit bashkëlidhur për mënyra se si të na kontaktoni.