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, go to www.bcbswny.com or call 1-888-839-5169. 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 http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-888-839-5169 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $0; for out-of-network providers $750 individual /$1,500 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, network providers services and prescription drugs are not subject to a deductible.	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/.
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?	For network providers $3,000 individual / $6,000 family; for out-of-network providers $3,750 individual / $7,500 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?	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.bcbswny.com or call 1-888-840-6322 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 in-network specialist you choose without permission from this plan

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment	25% coinsurance	None
	Specialist visit	$20 copayment	25% coinsurance	None
	Preventive care/screening/ immunization	Covered in full	25% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Flu vaccine covered in full out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	Covered in full for blood work, $20 copayment for x-ray	25% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$20 copayment	25% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbswny.com	Generic drugs (Tier 1)	$5 copayment	Not covered	Some generic drugs may be subject to non-preferred brand copayment.
	Preferred brand drugs (Tier 2)	$20 copayment	Not covered	None
	Non-preferred brand drugs (Tier 3)	$35 copayment	Not covered	None
	Specialty drugs (Tier 4)	See Limitations & Exceptions	Not covered	Specialty drugs could be generic, preferred brand or non-preferred brand. Please visit www.bcbswny.com for a copy of the medication guide.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$20 copayment	25% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
	Physician/surgeon fees	Covered in full	25% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
If you need immediate medical attention	Emergency room care	$150 copayment	$150 copayment	None
	Emergency medical transportation	$50 copayment	$50 copayment	
	Urgent care	$20 copayment	25% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 per year	25% coinsurance	$250 inpatient copayment is paid once per year, even if a member has multiple inpatient

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				stays in a calendar year
	Physician/surgeon fees	Covered in full	25% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment for Mental Health $20 copayment for Substance Abuse	25% coinsurance for Mental Health 25% coinsurance for Substance Abuse	None
	Inpatient services	$250 per year for Inpatient Mental Health, Substance Abuse detox, or Substance Abuse rehab	25% coinsurance for Mental Health 25% coinsurance for Substance Abuse detox 25% coinsurance for Substance Abuse Rehab	$250 inpatient copayment is paid once per year, even if a member has multiple inpatient stays in a calendar year
If you are pregnant	Office visits	$20 copayment	25% coinsurance	For network providers, copayment applies only to initial visit to determine pregnancy. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$250 copayment	25% coinsurance	$250 inpatient copayment is paid once per year, even if a member has multiple inpatient stays in a calendar year
	Childbirth/delivery facility services	$250 copayment	25% coinsurance	
If you need help recovering or have other special health needs	Home health care	$0 copayment	25% coinsurance	None
	Rehabilitation services	$20 copayment	25% coinsurance	30 visits per year, per therapy; Separate limits for physical, speech and occupational therapy
	Habilitation services	$20 copayment	25% coinsurance	None
	Skilled nursing care	Covered in full	25% coinsurance	None
	Durable medical equipment	50% coinsurance	50% coinsurance	Prior authorization required on certain equipment. Call the number on the back of your ID card for details.
	Hospice services	Covered in full	25% coinsurance	210 days maximum
If your child needs	Children's eye exam	$0 copayment	25% coinsurance	Covered in full for 1 routine per year

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
dental or eye care	Children's glasses	See limitations and exceptions	Not covered	Discounts may apply.
	Children's dental check-up	See limitations and exceptions	See limitations and exceptions	Contact your group administrator for coverage details.

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 (Adult)
- Custodial Care
- Private-duty nursing
- Hearing aids
- Weight loss programs

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

- Acupuncture
- Habilitation Services
- Routine foot care
- Bariatric Surgery
- Infertility treatment
- Routine eye care (Adult)
- Chiropractic Care
- 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 are the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or 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. 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: 1-888-840-6322.

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 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.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-249-2583.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-249-2583.
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-888-249-2583.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-249-2583.

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	$20
Hospital (facility) copayment	$250
Other copayment	$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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$670
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$730**

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	$20
Hospital (facility) copayment	$250
Other copayment	$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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$615
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$670**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$250
Other copayment	$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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$330
Coinsurance	$18
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$348**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.