

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 1-888-249-2583. 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.bcbswny.com or call 1-888-249-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Major Medical services: \$150/\$300	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. \$150/\$300 Major Medical 20% coinsurance services. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$500 individual/\$1,000 family	The out-of-pocket limit is the most you could pay in a year for covered services.
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 ?	Not Applicable	This plan does not use a provider network . You can receive covered services from any provider .
Do you need a referral to see a specialist ?	No	You can see the specialist 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.

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% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/immunization	20% coinsurance	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	Prior authorization required.
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)	\$10 co-pay/visit	\$10 co-pay/visit	Some generic drugs may be subject to non-preferred brand cost share .
	Preferred brand drugs (Tier 2)	\$25 co-pay/visit	\$25 co-pay/visit	None
	Non-preferred brand drugs (Tier 3)	\$25 co-pay/visit	\$25 co-pay/visit	None
	Specialty drugs (Tier 4)	See limitations & exceptions	Not Covered	Specialty drugs could be generic, preferred brand or non-preferred brand. Please visit our website for a copy of our medication guide.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
	Physician/surgeon fees	0% coinsurance	10% coinsurance for in area; 0% coinsurance for out of area	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	0% coinsurance	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	10% coinsurance	None
	Urgent care	0% coinsurance	0% coinsurance	None

If you have a hospital stay	Facility fee (e.g., hospital room)	Covered in full	20% coinsurance	Prior authorization required.
	Physician/surgeon fees	0% coinsurance	10% coinsurance for in area; 0% coinsurance for out of area	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	0% coinsurance	None
	Inpatient services	Covered in full	20% coinsurance	Prior authorization required.
If you are pregnant	Office visits	0% coinsurance	0% coinsurance	For participating providers , cost share applies only to initial visit to determine pregnancy.
	Childbirth/delivery professional services	Covered in full	20% coinsurance	For participating providers , cost share applies only to initial visit to determine pregnancy.
	Childbirth/delivery facility services	Covered in full	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Prior authorization required.
	Rehabilitation services	20% coinsurance	20% coinsurance	None
	Habilitation services	20% coinsurance	20% coinsurance	None
	Skilled nursing care	20% coinsurance	20% coinsurance	Prior authorization required.
	Durable medical equipment	20% coinsurance	20% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
	Hospice services	0% coinsurance	0% coinsurance	None
If your child needs dental or eye care	Children's eye exam	See limitations & exceptions	See limitations & exceptions	Member cost share may vary by plan.
	Children's glasses	See limitations & exceptions	Not covered	Discounts may apply.
	Children's dental check-up	See limitations & exceptions	See limitations & 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](#).)

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|--|---|---|
| <ul style="list-style-type: none">• Acupuncture• Hearing Aids | <ul style="list-style-type: none">• Custodial Care• Long Term Care• Routine Foot Care | <ul style="list-style-type: none">• Dental care (Adult)• Private Duty Nursing• Weight Loss Programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none">• Bariatric surgery• Routine Eye Care (Adult) | <ul style="list-style-type: none">• Chiropractic care• Infertility treatment |
|--|---|

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: 1-888-249-2583.

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 Coverage? **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, kwijigo 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	\$150.00
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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	\$12,731
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles*	\$150
Copays	\$0
Coinsurance	\$58
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$268

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$150.00
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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	\$7,389
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$150
Copays	\$0
Coinsurance	\$2,342
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,547

Mia's Simple Fracture

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

■ The plan's overall deductible	\$150.00
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$150
Copays	\$0
Coinsurance	\$260
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$410

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: BlueCross BlueShield of Western New York at www.bcbswny.com or call 1-888-249-2583. *Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.