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, visit 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?	None.	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	None.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	In-network providers: $3,000/$6,000 Out-of-network providers: None	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Copayments for certain 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.bcbswny.com or call 1-888-249-2583 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 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	$10 copay/visit	Not Covered	
	Specialist visit	$18 copay/visit	Not Covered	
	Preventive care/screening/ immunization	$0 copay/visit	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	$18 copay/visit for x-ray, $0 copay/visit for bloodwork	Not Covered	
	Imaging (CT/PET scans, MRIs)	$18 copay/visit	Not Covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbswny.com	Generic drugs	$5 copay/visit	Not covered	Some generic drugs may be subject to non-preferred brand cost share.
	Preferred brand drugs	$30 copay/visit	Not covered	
	Non-preferred brand drugs	$60 copay/visit	Not covered	
	Specialty drugs	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)	$100 copay/visit	Not Covered	Preauthorization requirements may apply
	Physician/surgeon fees	$18 copay/visit	Not Covered	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copay waived if admitted
	Emergency medical transportation	$100 copay/visit	$100 copay/visit	Medically necessary transportation only
	Urgent care	$25 copay/visit	$25 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 copay/visit	Not Covered	Preauthorization requirements may apply
	Physician/surgeon fees	$0 copay/visit	Not Covered	

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit	Not Covered	
	Inpatient services	$0 copay/visit	Not Covered	
If you are pregnant	Office visits	$10 co-pay/visit	Not Covered	For participating providers, cost share applies only to initial visit to determine pregnancy. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$0 copay/visit	Not Covered	
	Childbirth/delivery facility services	$0 copay/visit	Not Covered	
If you need help recovering or have other special health needs	Home health care	$18 copay/visit	Not Covered	
	Rehabilitation services	$18 copay/visit	Not Covered	20 visits per Plan Year combined therapies
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	$0 copay/visit	Not Covered	50 days per Plan Year
	Durable medical equipment	50% coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	$0 copay/visit	Not Covered	
If your child needs dental or eye care	Children's eye exam	See limitations and exceptions	See limitations and exceptions	Member cost share may vary by plan.
	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.)

- Acupuncture
- Custodial care
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight Loss programs

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

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Hearing Aid
- Routine eye care (Adult)

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: New York State, HHS, DOL, and/or other applicable agency contact information. 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 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.

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	$18
Hospital (facility) copayment	$0
Other copayment	$18

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	$13,051

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$230
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$290

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	$18
Hospital (facility) copayment	$0
Other copayment	$18

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

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,345
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,400

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

The plan's overall deductible	$0
Specialist copayment	$18
Hospital (facility) copayment	$0
Other copayment	$18

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	$2,012

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$540
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$558