

 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.bsneny.com](http://www.bsneny.com) or call 1-800-888-1238. 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.bsneny.com](http://www.bsneny.com) or call 1-800-888-1238 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In- <a href="#">network</a> : N/A; Out-of- <a href="#">network</a> : \$200/\$400/\$600	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 <a href="#">plan</a> , 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. No services are subject to a <a href="#">deductible</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. This <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost-sharing 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- <a href="#">network</a> : \$6,350 individual/ \$12,700 family; Out-of- <a href="#">network</a> : \$2,000 individual / \$4,000 family	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> ?	Premiums, balance-billing 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.bsneny.com">www.bsneny.com</a> or call 1-800-888-1238 for a list of <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 an out-of- <a href="#">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 out-of- <a href="#">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 <a href="#">referral</a> .



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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$10 <a href="#">copayment</a>	20% coinsurance	None
	<a href="#">Specialist</a> visit	\$10 <a href="#">copayment</a>	20% coinsurance	None
	<a href="#">Preventive care/screening</a> /immunization	Covered in full	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. Flu vaccine covered in full out-of- <a href="#">network</a> .
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	\$0 copayment	20% coinsurance	
	Imaging (CT/PET scans, MRIs)	\$0 copayment	20% coinsurance	None
<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.bsneny.com">www.bsneny.com</a>	Generic drugs (Tier 1)	\$1 <a href="#">copayment</a>	Not covered	Some generic drugs may be subject to non-preferred brand <a href="#">cost share</a> .
	Preferred brand drugs (Tier 2)	\$3 <a href="#">copayment</a>	Not covered	None
	Non-preferred brand drugs (Tier 3)	\$3 <a href="#">copayment</a>	Not covered	None
	<a href="#">Specialty drugs</a> (Tier 4)	See limitations & exceptions	See limitations & exceptions	Specialty drugs could be generic, preferred brand or non-preferred brand. Please visit our website for a copy of our medication guide.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Covered in full	20% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
	Physician/surgeon fees	\$0 copayment	20% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$0 copayment	<a href="#">Covered as In network</a>	None
	<a href="#">Emergency medical transportation</a>	\$0 copayment	<a href="#">Covered as In network</a>	
	<a href="#">Urgent care</a>	\$10 <a href="#">copayment</a>	20% coinsurance	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Covered in full	20% coinsurance	
	Physician/surgeon fees	Covered in full	20% coinsurance	None

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	\$0 copayment	20% coinsurance	None
	Inpatient services	\$0 copayment	20% coinsurance	Unlimited visits, subject to medical necessity
If you are pregnant	Office visits	\$10 <a href="#">copayment</a>	20% coinsurance	None
	Childbirth/delivery professional services	\$10 <a href="#">copayment</a>	20% coinsurance	For participating <a href="#">providers</a> , <a href="#">cost share</a> 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	<a href="#">Home health care</a>	\$0 copayment	20% coinsurance	No visit limits/cal yr; aggregate IN & OON
	<a href="#">Rehabilitation services</a>	\$0 copayment	20% coinsurance	90 visits aggregate IN & OON per cal year
	<a href="#">Skilled nursing care</a>	Covered in full	20% coinsurance	120 days per <a href="#">plan</a> year IN + OON aggregate limit
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	20% coinsurance	None
	<a href="#">Hospice services</a>	\$0 copayment	20% coinsurance	Unlimited visits aggregate IN + OON
If your child needs dental or eye care	Children's eye exam	\$10 <a href="#">copayment</a>	20% coinsurance	Member <a href="#">cost share</a> may vary by <a href="#">plan</a> .
	Children's glasses	See limitations & exceptions	See limitations & exceptions	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](#).)

- Acupuncture
- Dental
- Routine Foot Care
- Cosmetic surgery
- Long Term Care
- Weight Loss Programs
- Custodial Care
- Private Duty Nursing

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

- Hearing Aids
- Routine Eye Care (Adult)
- Chiropractic care
- Elective Abortion
- 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 is: Department of Labor's 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 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: 1-800-888-1238.

### 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 1-800-888-1238.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-888-1238.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-888-1238.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-888-1238.

—————*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0.00
■ <a href="#">Specialist copayment</a>	\$10.00
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$10.00

**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>\$12,891</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$0
Copays	\$194
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$254</b>

**Managing Joe's type 2 Diabetes**

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0.00
■ <a href="#">Specialist copayment</a>	\$10.00
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$10.00

**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>\$7,389</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$0
Copays	\$170
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$225</b>

**Mia's Simple Fracture**

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0.00
■ <a href="#">Specialist copayment</a>	\$10.00
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$10.00

**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>\$1,925</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$0
Copays	\$30
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$30</b>

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: BlueShield of Northeastern New York at [www.bsny.com](http://www.bsny.com) or call 1-800-888-1238.

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.