




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](http://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 <a href="#">deductible</a> ?	For <a href="#">network providers</a> \$0; for <a href="#">out-of-network providers</a> \$750 individual /\$1,500 family	Generally, you must pay all of the costs from providers 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, <a href="#">network providers</a> services and prescription drugs are not 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. 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> ?	For <a href="#">network providers</a> \$3,000 individual / \$6,000 family; for <a href="#">out-of-network providers</a> \$3,750 individual / \$7,500 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 out-of-pocket limits 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> ?	<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.bcbswny.com">www.bcbswny.com</a> or call 1-888-840-6322 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's 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 in-network <a href="#">specialist</a> 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)	
<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	\$20 <a href="#">copayment</a>	25% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copayment</a>	25% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	Covered in full	25% <a href="#">coinsurance</a>	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-network.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Covered in full for blood work, \$20 <a href="#">copayment</a> for x-ray	25% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	\$20 <a href="#">copayment</a>	25% <a href="#">coinsurance</a>	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.bcbswny.com">www.bcbswny.com</a>	Generic drugs (Tier 1)	\$5 <a href="#">copayment</a>	Not covered	Some generic drugs may be subject to non-preferred brand <a href="#">copayment</a> .
	Preferred brand drugs (Tier 2)	\$20 <a href="#">copayment</a>	Not covered	None
	Non-preferred brand drugs (Tier 3)	\$35 <a href="#">copayment</a>	Not covered	None
	<a href="#">Specialty drugs</a> (Tier 4)	See Limitations & Exceptions	Not covered	Specialty drugs could be generic, preferred brand or non-preferred brand. Please visit <a href="http://www.bcbswny.com">www.bcbswny.com</a> for a copy of the medication guide.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$20 <a href="#">copayment</a>	25% <a href="#">coinsurance</a>	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% <a href="#">coinsurance</a>	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>	\$150 <a href="#">copayment</a>	\$150 <a href="#">copayment</a>	None
	<a href="#">Emergency medical transportation</a>	\$50 <a href="#">copayment</a>	\$50 <a href="#">copayment</a>	
	<a href="#">Urgent care</a>	\$20 <a href="#">copayment</a>	25% <a href="#">coinsurance</a>	

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 have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 per year	25% <a href="#">coinsurance</a>	\$250 inpatient copayment is paid once per year, even if a member has multiple inpatient stays in a calendar year
	Physician/surgeon fees	Covered in full	25% <a href="#">coinsurance</a>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <a href="#">copayment</a> for Mental Health \$20 <a href="#">copayment</a> for Substance Abuse	25% <a href="#">coinsurance</a> for Mental Health 25% <a href="#">coinsurance</a> for Substance Abuse	None
	Inpatient services	\$250 per year for Inpatient Mental Health, Substance Abuse detox, or Substance Abuse rehab	25% <a href="#">coinsurance</a> for Mental Health 25% <a href="#">coinsurance</a> for Substance Abuse detox 25% <a href="#">coinsurance</a> for Substance Abuse Rehab	\$250 inpatient copayment is paid once per year, even if a member has multiple inpatient stays in a calendar year
<b>If you are pregnant</b>	Office visits	\$20 <a href="#">copayment</a>	25% <a href="#">coinsurance</a>	For <a href="#">network providers</a> , <a href="#">copayment</a> 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 <a href="#">copayment</a>	25% <a href="#">coinsurance</a>	\$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 <a href="#">copayment</a>	25% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$0 <a href="#">copayment</a>	25% <a href="#">coinsurance</a>	None
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copayment</a>	25% <a href="#">coinsurance</a>	30 visits per year, per therapy; Separate limits for physical, speech and occupational therapy
	<a href="#">Habilitation services</a>	\$20 <a href="#">copayment</a>	25% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	Covered in full	25% <a href="#">coinsurance</a>	None
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Prior authorization required on certain equipment. Call the number on the back of your ID card for details.
	<a href="#">Hospice services</a>	Covered in full	25% <a href="#">coinsurance</a>	210 days maximum

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 your child needs dental or eye care	Children's eye exam	\$0 <a href="#">copayment</a>	25% <a href="#">coinsurance</a>	Covered in full for 1 routine per year
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Custodial Care</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Habilitation Services</li> <li>• Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Infertility treatment</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>

**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](http://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](http://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](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: 1-888-840-6322.

**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, 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$670
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$730</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
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$615
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$670</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
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

#### In this example, Mia would pay:

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