
 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 <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-888-249-2583 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>For network providers \$0; for out-of-network providers Core: \$1,000 individual /\$3,000 family Advantage: \$250 individual/\$500 family</p>	<p>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</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes, network providers services and prescription drugs are not subject to a deductible.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For network providers \$6,350 individual / \$12,700 family; for out-of-network providers Core \$5,000 individual / \$10,000 family Advantage: \$2,000 individual/\$4,000 family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.bcbswny.com or call 1-888-249-2583 for a list of network providers.</p>	<p>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.</p>

Do you need a referral to see a specialist ?	No.	You can see the in-network specialist you choose without permission from this plan
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 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	\$5 copayment	Core: 25% coinsurance Advantage:20% coinsurance	Advantage Option 2 \$0 copayment Advantage Option 3 \$5 copayment
	Specialist visit	\$10 copayment	Core: 25% coinsurance Advantage:20% coinsurance	Advantage Option 2 \$15 copayment Advantage Option 3 \$10 copayment
	Preventive care/screening/immunization	Covered in full	Core: 25% coinsurance Advantage:20% 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	Core: 25% coinsurance Advantage:20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Covered in full	Core: 25% coinsurance Advantage:20% 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)	\$7 copayment	Not covered	Some generic drugs may be subject to non-preferred copayment .
	Preferred brand drugs (Tier 2)	\$15 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 our website for a copy of our medication guide.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Specialist copayment	Core: 25% coinsurance Advantage:20% 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	Core: 25% coinsurance Advantage:20% 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	\$35 copayment	\$35 copayment	None
	Emergency medical transportation	Covered in full	Covered in full	
	Urgent care	PCP copayment	Core: 25% coinsurance Advantage:20% coinsurance	

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 have a hospital stay	Facility fee (e.g., hospital room)	Covered in full	Core: 25% coinsurance Advantage:20% coinsurance	Prior authorization required.
	Physician/surgeon fees	Covered in full	Core: 25% coinsurance Advantage:20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Covered in full for Mental Health Covered in full for Substance Abuse	Core: 25% coinsurance Advantage:20% coinsurance	None
	Inpatient services	Covered in full for Inpatient Mental Health Covered in full for Substance Abuse detox Covered in full for Substance Abuse rehab	Core: 25% coinsurance Advantage:20% coinsurance	Prior authorization required.
If you are pregnant	Office visits	PCP copayment	Core: 25% coinsurance Advantage:20% 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	Covered in full	Core: 25% coinsurance Advantage:20% coinsurance	None
	Childbirth/delivery facility services	Covered in full	Core: 25% coinsurance Advantage:20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	Specialist copayment	Core: 25% coinsurance Advantage:20% coinsurance	None
	Rehabilitation services	Specialist copayment	Core: 25% coinsurance Advantage:20% coinsurance	20 visits per year. Includes physical therapy, occupational therapy, and speech therapy.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	Covered in full	Core: 25% coinsurance Advantage:20% coinsurance	Prior authorization required. 50 days per year.
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior authorization required on certain equipment. Call the number on the back of your ID card for details.

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)	
	Hospice services	Covered in full	Core: 25% coinsurance Advantage: 20% coinsurance	210 days maximum
If your child needs dental or eye care	Children's eye exam	PCP or Specialist copayment	Core: 25% coinsurance Advantage: 20% coinsurance	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	Not covered	Not covered	None

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 | • Cosmetic surgery | • Custodial Care |
| • Dental (Adult) | • Habilitation Services | • Hearing aids |
| • 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.)

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|------------------------------------------------------|----------------------------|-------------------------|
| • Bariatric Surgery | • Chiropractic Care | • Infertility treatment |
| • Non-emergency care when traveling outside the U.S. | • 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 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, 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](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$10

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$40
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$100

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](#) \$10
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$10

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$470
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$525

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$10

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$80
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$90