

 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](http://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](http://www.bcbswny.com) or call 1-888-249-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	None.	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	None.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <a href="#">deductibles</a> 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 <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-network providers: \$3,000/\$6,000 Out-of-network providers: None	The <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limit</a> ?	<b>Copayments</b> for certain services, <b>premiums</b> , <b>balance-billing</b> 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 1-888-249-2583 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 provider 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 plan pays (balance billing). 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 <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 copay/visit	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit	\$20 copay/visit	Not Covered	
	<a href="#">Preventive care/screening/immunization</a>	\$0 copay/visit	Not Covered	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$20 copay/visit for x-ray, \$0 copay/visit for bloodwork	Not Covered	
	Imaging (CT/PET scans, MRIs)	\$20 copay/visit	Not Covered	
<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	\$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	
	<a href="#">Specialty drugs</a>	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.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 copay/visit	Not Covered	Preauthorization requirements may apply
	Physician/surgeon fees	\$0 copay/visit	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 copay/visit	\$100 copay/visit	Copay waived if admitted
	<a href="#">Emergency medical transportation</a>	\$100 copay/visit	\$100 copay/visit	Medically necessary transportation only
	<a href="#">Urgent care</a>	\$35 copay/visit	Not Covered	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$0 copay/visit	Not Covered	Preauthorization requirements may apply
	Physician/surgeon fees	\$0 copay/visit	Not Covered	\$75 for surgery

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbswny.com](http://www.bcbswny.com).

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 need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 copay/visit	Not Covered	
	Inpatient services	\$0 copay/visit	Not Covered	
<b>If you are pregnant</b>	Office visits	\$20 co-pay/visit	Not Covered	For participating providers, cost share applies only to initial visit to determine pregnancy. <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> 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	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$20 copay/visit	Not Covered	
	<a href="#">Rehabilitation services</a>	\$20 copay/visit	Not Covered	
	<a href="#">Habilitation services</a>	\$20 copay/visit	Not Covered	
	<a href="#">Skilled nursing care</a>	\$0 copay/visit	Not Covered	
	<a href="#">Durable medical equipment</a>	50% coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	\$0 copay/visit	Not Covered	
<b>If your child needs dental or eye care</b>	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         | • Long-term care                                     | • Private-duty nursing |
| • Custodial care      | • Non-emergency care when traveling outside the U.S. | • Routine foot care    |
| • Dental care (Adult) |  | • 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 | • Infertility treatment | • Routine eye care (Adult) |
| • Chiropractic care |                         |                            |

**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](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: 1-888-249-2583.

**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, kwijigo holne' 1-888-249-2583.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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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](#) \$20
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$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>\$13,051</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$420
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$480</b>

**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](#) \$20
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$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>\$7,389</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$745
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$800</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [copayment](#) \$0
- Other [copayment](#) \$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>\$2,012</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$460
Coinsurance	\$99
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$559</b>