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.excellusbcbs.com/sebf or call 1-877-650-5840. 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.dol.gov/ebsa/healthreform or www.cciio.cms.gov or https://www.healthcare.gov/sbc-glossary or call 1-877-650-5840 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Calendar Year: In-network: Individual **$0** / Family **$0** Out-of-Network: Individual **$1,000**/ Family **$2,000**. Deductible does not apply to prescription drugs.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	**In-network: Not applicable since $0 deductible; Out-of-Outwork: Yes - Emergency medical transportation**	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/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Medical – In-network: Individual $5,150 / Family $7,900** **Out-of-network: None** **Prescriptions – Individual $1,200 / Family $4,800**	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 limit until the family out-of-pocket limit has been met.

What is not included in the out-of-pocket limit?	In-network: Premiums, balance-billed charges and health care this **plan** does not cover. Out-of-network: There are no **out-of-pocket limits**.	In-network: Even though you pay these expenses, they don't count toward the out-of-pocket limit. Out-of-network: This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Medical – Yes. For a list of in-network providers, see www.excellusbcbs.com/sebf or call 1-877-650-5840. .	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 a referral.

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	$40 copayment per visit	30% coinsurance	None
	Specialist visit	$40 copayment per visit	30% coinsurance	None
	Preventive care/screening/ Immunization	No charge for routine physical exam/immuni-zation, mammogram, routine prostate specific antigen and digital rectal exam, routine gynecology; $40 copayment per visit for speech/hearing exams.	30% coinsurance	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	If performed as part of a physician office visit and billed by the physician, expenses covered subject to applicable physician's office visit member cost sharing.
	Imaging (CT/PET scans, MRIs)	$75 copayment per visit	30% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.excellusbcbs.com/sebf.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.excellus.com/sebf.com or call 1-877-650-5840**	Generic drugs	30% coinsurance	30% coinsurance	Retail 30-day supply; Mail Order 60-day supply. Coverage is limited to 50% coinsurance for proton pump inhibitors and non-sedating (and low sedating) anti-histamines. Mandatory mail feature for maintenance or long term medications.
	Preferred brand drugs	30% coinsurance	30% coinsurance	
	Non-preferred brand drugs	30% coinsurance	30% coinsurance	
	Specialty drugs	30% coinsurance	30% coinsurance	Specialty drugs must be filled by Specialty Pharmacy **Accredo**. If your Specialty drug qualifies for the SavonSP Program, you must confirm enrollment in the SavonSP Program. Specialty drug cost sharing under the SavonSP Program does not count towards the out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copayment per visit	30% coinsurance	None
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copayment per visit, waived if admitted	$100 copayment per visit, waived if admitted	No coverage for non-emergency use.
	Emergency medical transportation	$50 copayment per transport	$50 copayment per transport, deductible waived	None
	Urgent care	$40 copayment per visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment per stay	30% coinsurance	In-network $1,500 maximum copayment per individual per calendar year. Preauthorization required for out-of-network care or a $400 penalty may apply.
	Physician/surgeon fees	No charge	30% 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	$40 copayment per visit	30% coinsurance	None
	Inpatient services	$500 copayment per stay	30% coinsurance	In-network $1,500 maximum copayment per individual per calendar year. Preauthorization required for out-of-network care or a $400 penalty may apply.
If you are pregnant	Office visits	No charge	30% coinsurance	None
	Childbirth/delivery professional services	No charge	30% coinsurance	None
	Childbirth/delivery facility services	$500 copayment per stay	30% coinsurance	$1,500 maximum copayment per individual per calendar year. Includes outpatient postnatal care. Preauthorization required for out-of-network care or a $400 penalty may apply.
If you need help recovering or have other special health needs	Home health care	$40 copayment per visit	25% coinsurance	Coverage is limited to 40 visits per calendar year. Preauthorization required for out-of-network care or a $400 penalty may apply.
	Rehabilitation services	$40 copayment per visit	30% coinsurance	Coverage is limited to 60 visits (Physical & Occupational Therapy combined). Coverage is limited to 20 visits (Speech Therapy).
	Habilitation services	$40 copayment per visit	30% coinsurance	None
	Skilled nursing care	$500 copayment per stay	30% coinsurance	Coverage is limited to 60 days per calendar year. In-network $1,500 maximum copayment per individual per calendar year. Preauthorization required for out-of-network care or a $400 penalty may apply.
	Durable medical equipment	20% coinsurance	30% coinsurance	None
	Hospice services	Inpatient: $500 copayment per stay. Outpatient: No charge	30% coinsurance	In-network $1,500 maximum copayment per individual per calendar year. Preauthorization required for out-of-network care or a $400 penalty may apply.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)

- Acupuncture – coverage is limited to treatment of illness or injury (20 visits per calendar year)
- Bariatric surgery
- Chiropractic care – coverage is limited to 20 visits per calendar year
- Hearing aids – coverage is limited to a maximum of $2,500 every 12 months
- Infertility treatment – coverage is limited to the diagnosis and treatment of underlying medical condition

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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: the plan at 1-877-650-5840. You may also contact the Department of Labor's Employee Benefit Security Administration at 1-866-444EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file an appeal. You can contact the Community Service Society of New York, Community Health Advocates at 1-888-614-5400 for further assistance.

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 1-877-650-5840.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-650-5840.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-650-5840.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-650-5840.

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

* For more information about limitations and exceptions, see the plan or policy document at www.excellusbcbs.com/sebf.

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	$40
Hospital (facility) copayment	$500
Other coinsurance	30%

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$10
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$570**

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	$40
Hospital (facility) copayment	$500
Other coinsurance	30%

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$1200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,660**

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$100
Other coinsurance	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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$440**

The plan would be responsible for the other costs of these EXAMPLE covered services.