

CROUSE HOSPITAL - Choice Plan
General Information
Cost Sharing Expenses

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Deductible - Single	\$0	\$250	\$250	
Deductible - Plus 1/Family	\$0	\$750	\$750	Each individual does not exceed the single deductible.
Coinsurance	0%	20%	30%	Co-insurance is calculated on the allowed amount.
Annual Out of Pocket Maximum - Single	\$1,000	\$2,000	\$3,000	Out-of-pocket maximums include deductible, coinsurance and Medical copays. Domestic and INN aggregate together. RX Out of Pocket Maximum: \$6,000 individual/ \$11,700 family not combined with medical Out-of-Pocket Maximum.
Annual Out of Pocket Maximum - Plus 1	\$2,000	\$3,000	\$4,000	Out-of-pocket maximums include deductible, coinsurance and Medical copays. Domestic and INN aggregate together. RX Out of Pocket Maximum: \$6,000 individual/ \$11,700 family not combined with medical Out-of-Pocket Maximum.
Annual Out of Pocket Maximum - Family	\$3,000	\$4,000	\$6,000	Same as above for Plus 1 plan

Office Visit Cost Shares

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	\$20 Copayment	\$45 Copayment	30% Coinsurance Subject to Deductible	Co-insurance is calculated on the allowed amount
Cost Share - Specialist	\$20 Copayment	\$45 Copayment	30% Coinsurance Subject to Deductible	Co-insurance is calculated on the allowed amount

Plan Limits

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year				Calendar Year Benefits
Diabetic Preauthorization and Step Therapy				Yes

Who is Covered

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage				Not Covered

Inpatient Services

Inpatient Facility

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	Covered in Full	\$2,000 Copayment	\$2,000 Copayment Subject to Deductible	INN/OON Copay DOES NOT apply to dependents under 19 yrs of age. Maximum 3 copays per yr. applies to INN only. OON 30% Coinsurance after copay and deductible.
Mental Health Care	Covered in Full	\$2,000 Copayment	\$2,000 Copayment Subject to Deductible	INN/OON Copay DOES NOT apply to dependents under 19 yrs of age. Maximum 3 copays per yr. applies to INN only. OON 30% Coinsurance after copay and deductible.
Substance Use Detoxification	Covered in Full	\$2,000 Copayment	\$2,000 Copayment Subject to Deductible	INN/OON Copay DOES NOT apply to dependents under 19 yrs of age. Maximum 3 copays per yr. applies to INN only. OON 30% Coinsurance after copay and deductible.
Skilled Nursing Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	120 Days per year Limits are combined INN and OON.
Physical Rehabilitation	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	120 Visits per year Limits are combined INN and OON.
Maternity Care	Covered in Full	\$2,000 Copayment	\$2,000 Copayment	INN/OON Copay DOES NOT apply to dependents under 19 yrs of age. Maximum 3 copays per yr. applies to INN only. OON 30% Coinsurance after copay and deductible.

Inpatient Professional Services

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	Covered in Full	\$500 Copayment	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	Covered in Full	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	INN Deductible waived for Genetic Testing
Radiation Therapy	Covered in Full	20% Coinsurance	30% Coinsurance Subject to Deductible	
Chemotherapy	Covered in Full	20% Coinsurance	30% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Inclusive of Primary Service	

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Dialysis	Covered in Full	20% Coinsurance	30% Coinsurance Subject to Deductible	
Mental Health Care	\$20 Copayment	\$25 Copayment	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	\$20 Copayment	\$25 Copayment	30% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	40 Visits per year Visits 41 - 365 Domestic - CIF, INN - 20% Coinsurance. OON: 30% Coinsurance, after deductible. Limits are combined INN and OON

Home Infusion Therapy	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	
-----------------------	-----------------	-----------------	---------------------------------------	--

Hospice Care

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	Professional interpretation charges Domestic/INN CIF, OON deductible and coins
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	Professional interpretation charges Domestic/INN CIF, OON deductible and coins INN: Deductible waived for Genetic Testing
Radiation Therapy	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - \$20 Copayment	PCP/Specialist - \$25 Copayment	30% Coinsurance Subject to Deductible	HYPNOTHERAPY - Domestic / INN / OON 50% up to \$50 , 4 visits/yr combined, does not apply to Ded or OOP. SMOKING CESSATION - Domestic / INN Covered in Full. Two attempts per year. No coverage OON.

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Maternity Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Initial Visit copay \$15 Domestic \$25 INN
Telehealth	PCP/Specialist - \$20 Copayment	PCP/Specialist - \$45 Copayment	30% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	
Chiropractic Care	PCP/Specialist - \$20 Copayment	PCP/Specialist - \$20 Copayment	50% Coinsurance	20 visits per year. OON - 50% up to \$50 max per visit.
Allergy Testing	PCP/Specialist - \$20 Copayment	PCP/Specialist - \$45 Copayment	30% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	PCP/Specialist - \$45 Copayment	30% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums). Serum Domestic/ INN CIF, OON deductible and coins
Hearing Evaluations Routine	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	Covered in Full	

Rehab and Habilitation

Outpatient Facility

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	Covered in Full	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical and occupational therapy.
Occupational Rehabilitation	Covered in Full	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year 45 Limit combined with Physical Rehabilitation
Speech Rehabilitation	Covered in Full	20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Not combined with Physical or Occupational.

Outpatient Professional Services

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year Includes aggregate of visits for INN and OON and professional and facility covered services for physical and occupational therapy. Massage Therapy 50% to \$35 - Domestic, IN and Out. 16 Visit combined Max
Occupational Rehabilitation	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year 45 Limit combined with Physical Rehabilitation.
Speech Rehabilitation	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible	45 Visits per year Not combined with Physical or Occupational

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per calendar year
Adult Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Per AAP Guidelines
Routine GYN Visit	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 per calendar year
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Initial Co-pay applies for Domestic and INN
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per year
Mammography Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	NYS Prostate Cancer Testing Mandate applies.
Mammography Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	Covered in Full	30% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Covered through the Rx Benefit if purchased through the Pharmacy
Treatment of Diabetes - Insulin	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Covered through the Rx Benefit if purchased through the Pharmacy
Diabetic Equipment	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	Covered through the Rx Benefit if purchased through the Pharmacy
Durable Medical Equipment (DME)	PCP/Specialist - Covered in Full	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - Covered in Full	PCP/Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - 50% Coinsurance	PCP/Specialist - 50% Coinsurance	50% Coinsurance	16 Visits per year 50% up to \$50 max per visit.
Private Duty Nursing	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	

Diagnoses

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Not Covered	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	Covered in Full	\$100 Copayment	\$100 Copayment	Copay waived for Dependents under 19 Emergency. Domestic CIF for Emergency and Non-Emergency Services. INN \$100 copay, OON \$100 copay then 30%.

Transportation

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	Not Covered	\$100 Copayment	\$100 Copayment	Domestic Not Available

Urgent Care

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	Covered in Full	\$70 Copayment	30% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	N/A	N/A	N/A	Routine Adult Eyewear is not covered. Eyewear is only covered if following Intraocular Surgery or Cataract Surgery: Limit Once Every 24 months. Domestic and INN CIF, OON Deductible/ Coinsurance

Rx Benefits

Rx Plan				
Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Rx Plan				Custom Rx

Rx Benefits

Benefit Name	Crouse Domestic	Excellus In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	100	30		
Days Supply Per Mail Order	N/A	N/A		
Copays Per Mail Order Supply	N/A	N/A		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Excellus BCBS: Excellus BluePPo

A nonprofit independent licensee of the BlueCross BlueShield Association

CROUSE HOSPITAL - Choice Plan Ind/Family
Coverage Period: 01/01/2025 - 12/31/2025
Coverage for: Family | Plan Type: PPo



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, call 1-800-499-1275 or visit Our website at www.excellusbcbs.com. 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.ccio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Provider: \$0 Individual/\$0 Two Person/\$0 Family; Non-Preferred Provider: \$250 Individual/\$500 Two Person/\$750 Family; Out-of-Network: \$250 Individual/\$500 Two Person/\$750 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes, <u>Preventive Care</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Preferred Provider: \$1,000 Individual/N/A Two Person/\$3,000 Family; Non-Preferred Provider: \$2,000 Individual/N/A Two Person/\$4,000 Family; Out-of-Network: \$3,000 Individual/N/A Two Person/\$6,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Costs for <u>premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in Preferred Provider network. You pay more if you use a <u>provider</u> in Non-Preferred Provider network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay more)	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	\$20 Copay /visit	\$45 Copay /visit Deductible does not apply	30% Coinsurance	None
	Specialist visit	\$20 Copay /visit	\$45 Copay /visit Deductible does not apply	30% Coinsurance	
	Preventive care/screening/immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: 30% Coinsurance Adult Immunizations: 30% Coinsurance Well Child Visit: 30% Coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: No Charge Blood Work: No Charge	X-Ray: 20% Coinsurance Blood Work: 20% Coinsurance	X-Ray: 30% Coinsurance Blood Work: 30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% Coinsurance	30% Coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.excellusbcds.com/rxlist	Tier 1 (Generic drugs)	\$4/prescription retail, N/A/prescription mail order Deductible does not apply	40% Coinsurance Deductible does not apply	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription Preauthorization required for certain prescription drugs . If you don't get a preauthorization , you must pay the entire cost of the drug. Accelerated approved drugs are not covered unless the manufacturer participates in the Medication Assurance Program.
	Tier 2 (Preferred brand drugs)	\$30/prescription retail, N/A/prescription mail order Deductible does not apply	40% Coinsurance Deductible does not apply	Not Covered	
	Facility fee (e.g., ambulatory surgery center)	No Charge	\$500 Copay Deductible does not apply	30% Coinsurance	
If you have outpatient surgery	Physician/surgeon fees	No Charge	No Charge Deductible does not apply	30% Coinsurance	None

* For more information about limitations and exceptions, see [plan](#) or policy document at www.excellusbcds.com

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No Charge	\$100 Copay /visit Deductible does not apply	\$100 Copay /visit Deductible does not apply	None
	Emergency medical transportation	Not Covered	\$100 Copay /visit Deductible does not apply	\$100 Copay /visit Deductible does not apply	None
	Urgent care	No Charge	\$70 Copay /visit Deductible does not apply	30% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	\$2,000 Copay Deductible does not apply	\$2,000 Copay	None
	Physician/surgeon fees	No Charge	No Charge Deductible does not apply	30% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 Copay /visit	\$25 Copay /visit Deductible does not apply	30% Coinsurance	None
	Inpatient services	No Charge	\$2,000 Copay Deductible does not apply	\$2,000 Copay	
	Office visits	No Charge	No Charge Deductible does not apply	30% Coinsurance	
If you are pregnant	Childbirth/delivery professional services	No Charge	No Charge Deductible does not apply	30% Coinsurance	None
	Childbirth/delivery facility services	No Charge	\$2,000 Copay Deductible does not apply	\$2,000 Copay	
	Home health care	No Charge	No Charge Deductible does not apply	30% Coinsurance	
If you need help recovering or have other special health needs	Rehabilitation services	No Charge	20% Coinsurance	30% Coinsurance	45 Visits per year limit
	Habitatation services	No Charge	20% Coinsurance	30% Coinsurance	45 Visits per year limit
	Skilled nursing care	No Charge	No Charge Deductible does not apply	30% Coinsurance	\$2,000 Coinsurance after 120 day limit
	Durable medical equipment	No Charge	No Charge Deductible does not apply	30% Coinsurance	None
	Hospice services	No Charge	No Charge Deductible does not apply	30% Coinsurance	Family bereavement counseling limited to 5 Visits lifetime

* For more information about limitations and exceptions, see [plan](#) or policy document at www.excellusbcds.com

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	None
	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 - Long-term care - Routine eye care (Child)	- Dental care (Adult) - Private-duty nursing - Routine foot care	- Dental care (Child) - Routine eye 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.)

- Acupuncture - Hearing aids	- Bariatric surgery - Infertility treatment	- Chiropractic care - 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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. 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 phone number on Your ID card or www.excellusbcbs.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc> and www.cms.gov/CILIO/Resources/Consumer-Assistance-Grants.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

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](#).

* For more information about limitations and exceptions, see [plan](#) or policy document at www.excellusbcbs.com

-----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 [plan](#) or policy document at www.excellusbcb.com

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
- [Copayment](#) \$20
- [Hospital \(facility\) copayment](#) \$0
- [Other copayment](#) \$0

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	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

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

Managing Joe's type 2 Diabetes

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

- **The [plan's](#) overall [deductible](#)** \$0
- [Copayment](#) \$20
- [Hospital \(facility\) copayment](#) \$0
- [Other copayment](#) \$0

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	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$20

Mia's Simple Fracture

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

- **The [plan's](#) overall [deductible](#)** \$0
- [Copayment](#) \$20
- [Hospital \(facility\) copayment](#) \$0
- [Other copayment](#) \$0

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	\$2,800
---------------------------	----------------

In this example, Mia would pay:

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

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.