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 www.bcbswny.com or call 1-888-249-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $600 individual / $1,200 family; Out-of-network: $5,000 individual / $10,000 family	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.
Are there services covered before you meet your deductible?	Yes, preventive services and office based services are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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?	In-network: $4,000 individual / $8,000 family; Out-of-network: $10,000 individual / $20,000 family	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbswny.com or call 1-888-249-2583 for a list of network providers.	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	$25 copayment	50% coinsurance	None
	Specialist visit	$40 copayment	50% coinsurance	None
	Preventive care/screening/immunization	Covered in full	50% 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)	$40 copayment	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$40 copayment	50% coinsurance	Prior authorization required. OON providers are subject to review for medical necessity.
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)	$10 copayment	Not covered	Some generic drugs may be subject to non-preferred brand cost share.
	Preferred brand drugs (Tier 2)	$35 copayment	Not covered	None
	Non-preferred brand drugs (Tier 3)	$70 copayment	Not covered	None
	Specialty drugs (Tier 4)	See limitations & exceptions	See limitations & exceptions	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)	$100 copayment	50% 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	50% coinsurance	Prior authorization required.
If you need immediate medical attention	Emergency room care	$150 copayment	Covered as in-network	None
	Emergency medical transportation	$150 copayment	Covered as in-network	None
	Urgent care	$60 copayment	$60 copayment	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 have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copayment	50% coinsurance	Prior authorization required.
	Physician/surgeon fees	Covered in full	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment for Mental Health; $25 copayment for Substance Abuse	50% coinsurance for Mental Health; 50% coinsurance for Substance Abuse	Up to 20 visits a year may be used for family counseling
	Inpatient services	$1,000 copayment for Mental Health; $1,000 copayment for Substance Abuse Detox; $1,000 copayment for Substance Abuse Rehab	50% coinsurance for Mental Health; 50% coinsurance for Substance Abuse Detox; 50% coinsurance for Substance Abuse Rehab	Prior authorization required.
If you are pregnant	Office visits	$25 copayment	50% coinsurance	None
	Childbirth/delivery professional services	$25 copayment	50% coinsurance	Cost-share applied to initial visit for physician fee/ maternity care; additional services will take cost-share
	Childbirth/delivery facility services	$1,000 copayment	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	$25 copayment	50% coinsurance	40 aggregate visits per year; Home Infusion counts toward home health care visit limit.
	Rehabilitation services	$30 copayment	50% coinsurance	60 combined PT/OT/ST visits per condition per plan year
	Habilitation services	$30 copayment	50% coinsurance	60 combined PT/OT/ST visits per condition per plan year
	Skilled nursing care	$1,000 copayment	50% coinsurance	Prior authorization required. 200 days per year
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your id card for details.
	Hospice services	$25 copayment	50% coinsurance	210 days per year

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	$25 copayment	Not covered	Member cost share may vary by plan.
	Children's glasses	10% coinsurance	Not covered	Discounts may apply.
	Children's dental check-up	See limitations & exceptions	See limitations & exceptions	Coverage available through a separate dental plan.

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	• Long Term Care	• 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.)		
• Abortion	• Bariatric surgery	• Chiropractic care
• Hearing Aids	• Infertility treatment	• 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 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: 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 Minimum Value Coverage? 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, kwiijigo 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	$600.00
Specialist copayment	$40.00
Hospital (facility) copayment	$1,000.00
Other copayment	$25.00

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	**$13,515**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copays	$2,235
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,895**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$600.00
Specialist copayment	$40.00
Hospital (facility) copayment	$1,000.00
Other copayment	$25.00

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	**$7,906**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copays	$1,685
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,686**

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

The plan's overall deductible	$600.00
Specialist copayment	$40.00
Hospital (facility) copayment	$1,000.00
Other copayment	$25.00

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	**$2,971**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copays	$1,730
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,337**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: BlueCross BlueShield of Western New York at www.bcbswny.com or call 1-888-249-2583.

Notice of Nondiscrimination

BlueCross BlueShield of Western New York

BlueCross BlueShield of Western New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BlueCross BlueShield of Western New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BlueCross BlueShield of Western New York:

- 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 call the customer service number on the back of your ID card or contact the Director, Corporate Compliance and Privacy Officer.

If you believe that BlueCross BlueShield of Western New York 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:

Director, Corporate Compliance and Privacy Officer, 257 West Genesee Street, Buffalo, NY 14202, 1-800-798-1453, (716) 887-6056 (fax), complaint.compliance@bcbswny.com. You can file a grievance in person or by mail, fax, or email. 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, DC 20201, 1-800 -368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Notice of Nondiscrimination

BlueCross BlueShield of Western New York

For assistance in English, call customer service at the number listed on your ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کر یں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.