




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.bseny.com](http://www.bseny.com) or call [1-800-888-1238](tel:1-800-888-1238). 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:
What is the overall <a href="#">deductible</a> ?	In-network providers: None Out-of-Network providers: \$250/Individual and \$500/Family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive services</a> are not subject to the <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$4,500 individual / \$9,000 family; for <a href="#">out-of-network providers</a> \$2,500 individual / \$5,000 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 <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> 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.bseny.com">www.bseny.com</a> or call 1-800-888-1238 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 <a href="#">provider</a> 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 <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). 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 in-network specialist 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)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <a href="#">coinsurance</a>	Prior authorization required on certain procedures. Call the number on the back of your id card for details.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	Prior authorization required on certain procedures. Call the number on the back of your id card for details.
	Imaging (CT/PET scans, MRIs)	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bsny.com">www.bsny.com</a>	Generic drugs (Tier 1)	Not covered	Not covered	
	Preferred brand drugs (Tier 2)	Not covered	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	
	<a href="#">Specialty drugs</a> (Tier 4)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	Prior authorization required on certain procedures. Call the number on the back of your id card for details.
	Physician/surgeon fees	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$35 <a href="#">copay</a> / visit	\$35 <a href="#">copay</a> / visit	None
	<a href="#">Emergency medical transportation</a>	\$0 <a href="#">copay</a> / visit	\$0 <a href="#">copay</a> / visit	
	<a href="#">Urgent care</a>	\$10 <a href="#">copay</a> / visit	\$10 <a href="#">ccopay</a> / visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	Prior authorization required
	Physician/surgeon fees	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	Unlimited visits, up to 20 visits a year may be used for family counseling.
	Inpatient services	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	Prior authorization required on certain procedures. Call the number on the back of your id card for details.
<b>If you are pregnant</b>	Office visits	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	None
	Childbirth/delivery professional services	See comments	20% <a href="#">coinsurance</a>	\$10 Cost-share applied to initial visit for physician fee or maternity care; additional services will take a cost share as required.
	Childbirth/delivery facility services	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$10 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	100 aggregate visits per year; does not include home infusion therapy.
	<a href="#">Rehabilitation services</a>	\$10 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	60 combined rehabilitative PT/OT/ST visits per person, per year.
	<a href="#">Habilitation services</a>	\$10 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	60 combined habilitative PT/OT/ST visits per person, per year.
	<a href="#">Skilled nursing care</a>	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	120 days per year
	<a href="#">Durable medical equipment</a>	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	Prior authorization required on certain procedures. Call the number on the back of your id card for details.
	<a href="#">Hospice services</a>	\$0 <a href="#">copay</a> / visit	20% <a href="#">coinsurance</a>	210 days
<b>If your child needs dental or eye care</b>	Children's eye exam	\$0 <a href="#">copay</a> / visit	Not covered	Coverage limited to one exam/year. Discounts may apply.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	See limitations and exceptions	See limitations and exceptions	Contact your group administrator for 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          | • Cosmetic surgery     | • Dental (Adult)    |
| • Long Term Care       | • Custodial Care       | • Hearing Aids      |
| • Weight Loss Programs | • Private Duty Nursing | • Routine Foot Care |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                         |                            |  |
|-------------------------|----------------------------|--|
| • Bariatric Surgery     | • Chiropractic Care        | • Elective Abortion                                  |
| • Infertility treatment | • Routine Eye Care (Adult) | • 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 are the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://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](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 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)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
<ul style="list-style-type: none"> <li>■ The <a href="#">plan's</a> overall <a href="#">deductible</a> \$0</li> <li>■ <a href="#">Specialist cost share</a> \$10</li> <li>■ Hospital (facility) <a href="#">cost share</a> 0%</li> <li>■ Other <a href="#">cost share</a> 0%</li> </ul>	<ul style="list-style-type: none"> <li>■ The <a href="#">plan's</a> overall <a href="#">deductible</a> \$0</li> <li>■ <a href="#">Specialist cost share</a> \$10</li> <li>■ Hospital (facility) <a href="#">cost share</a> 0%</li> <li>■ Other <a href="#">cost share</a> 0%</li> </ul>	<ul style="list-style-type: none"> <li>■ The <a href="#">plan's</a> overall <a href="#">deductible</a> \$0</li> <li>■ <a href="#">Specialist cost share</a> \$10</li> <li>■ Hospital (facility) <a href="#">cost share</a> \$35</li> <li>■ Other <a href="#">cost share</a> 0%</li> </ul>
<p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>	<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>	<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>
<b>Total Example Cost</b> <b>\$7,540</b>	<b>Total Example Cost</b> <b>\$5,400</b>	<b>Total Example Cost</b> <b>\$1,925</b>
<b>In this example, Peg would pay:</b>	<b>In this example, Joe would pay:</b>	<b>In this example, Mia would pay:</b>
<i>Cost Sharing</i>	<i>Cost Sharing</i>	<i>Cost Sharing</i>
Deductibles      \$0	Deductibles*      \$0	Deductibles*      \$0
Copayments      \$10	Copayments      \$100	Copayments      \$85
Coinsurance      \$0	Coinsurance      \$0	Coinsurance      \$0
<i>What isn't covered</i>	<i>What isn't covered</i>	<i>What isn't covered</i>
Limits or exclusions      \$350	Limits or exclusions      \$2,980	Limits or exclusions      \$0
<b>The total Peg would pay is</b> <b>\$360</b>	<b>The total Joe would pay is</b> <b>\$3,080</b>	<b>The total Mia would pay is</b> <b>\$85</b>

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 [www.bseny.com](http://www.bseny.com) or call [1-800-888-1238](tel:1-800-888-1238). \*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

# Notice of Nondiscrimination



BlueShield of Northeastern 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. BlueShield of Northeastern New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BlueShield of Northeastern 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 BlueShield of Northeastern 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@bsneny.com](mailto:complaint.compliance@bsneny.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



**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 کریں۔

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.