




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.mycbswny.com/plans/essential-plan](http://www.mycbswny.com/plans/essential-plan) or call 1-866-231-0847. 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.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-866-231-0847 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$200	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	<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 <u>network provider</u> ?	Yes. See <a href="http://www.mycbswny.com/plans/find-doctors-locations">www.mycbswny.com/plans/find-doctors-locations</a> or call 1-866-231-0847 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use <u>an 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 <u>referral</u> to see a <u>specialist</u> ?	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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No charge	Not covered	Please see Subscriber Contract at <a href="http://www.mybcbswny.com/plans/essential-plan">www.mybcbswny.com/plans/essential-plan</a> for complete detail.
	<a href="#">Specialist</a> visit	No charge	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	Please see Subscriber Contract at <a href="http://www.mybcbswny.com/plans/essential-plan">www.mybcbswny.com/plans/essential-plan</a> for complete detail.
	Imaging (CT/PET scans, MRIs)	No charge	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.mybcbswny.com/plans/essential-plan">www.mybcbswny.com/plans/essential-plan</a>	Tier 1 (Generic drugs)	\$1 <a href="#">copay</a> /prescription (retail) \$2.50 <a href="#">copay</a> /prescription (mail order)	Not covered	Please see Subscriber Contract at <a href="http://www.mybcbswny.com/plans/essential-plan">www.mybcbswny.com/plans/essential-plan</a> for complete detail.
	Tier 2 (Preferred brand drugs or Formulary brand)	\$3 <a href="#">copay</a> /prescription (retail) \$7.50 <a href="#">copay</a> /prescription (mail order)	Not covered	
	Tier 3 (Non-preferred brand drugs or Non-formulary brand)	\$3 <a href="#">copay</a> /prescription (retail) \$7.50 <a href="#">copay</a> /prescription (mail order)	Not covered	
	<a href="#">Specialty drugs</a>	Same as tiered costs above	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Please see Subscriber Contract at <a href="http://www.mybcbswny.com/plans/essential-plan">www.mybcbswny.com/plans/essential-plan</a> for complete detail.
	Physician/surgeon fees	No charge	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document [www.mybcbswny.com/plans/essential-plan](http://www.mybcbswny.com/plans/essential-plan).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge	No charge	None
	<a href="#">Emergency medical transportation</a>	No charge	No charge	None
	<a href="#">Urgent care</a>	No charge	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Please see Subscriber Contract at <a href="http://www.mybcbswny.com/plans/essential-plan">www.mybcbswny.com/plans/essential-plan</a> for complete detail.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	Please see Subscriber Contract at <a href="http://www.mybcbswny.com/plans/essential-plan">www.mybcbswny.com/plans/essential-plan</a> for complete detail.
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Please see Subscriber Contract at <a href="http://www.mybcbswny.com/plans/essential-plan">www.mybcbswny.com/plans/essential-plan</a> for complete detail.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	Not covered	40 visit limit
	<a href="#">Rehabilitation services</a>	No charge	Not covered	60 visit limit per condition, applied to all therapies combined
	<a href="#">Habilitation services</a>	No charge	Not covered	60 visit limit per condition, applied to all therapies combined
	<a href="#">Skilled nursing care</a>	No charge	Not covered	200 day limit
	<a href="#">Durable medical equipment</a>	No charge	Not covered	Please see Subscriber Contract at <a href="http://www.mybcbswny.com/plans/essential-plan">www.mybcbswny.com/plans/essential-plan</a> for complete detail.
	<a href="#">Hospice services</a>	No charge	Not covered	210 day limit
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## 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      | • Non-emergency care when traveling outside the U.S. | • Routine foot care    |
| • Cosmetic surgery | • Private-duty nursing                               | • Weight loss programs |
| • Long-term care   |  |                        |

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

- |                     |   |                            |
|---------------------|---|----------------------------|
| • Abortion          | • Dental care (Adult)                           | • Routine eye care (Adult) |
| • Bariatric surgery | • Hearing aids (One purchase every three years) |                            |
| • Chiropractic care | • Infertility treatment                         |                            |

**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: Highmark Blue Cross Blue Shield at [www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans) or call 1-866-231-0847, New York State Department of Financial Services at [www.dfs.ny.gov](http://www.dfs.ny.gov) or call 1-800-342-3736, Community Service Society of New York at [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org) or call 1-888-614-5400, or NY State of Health: [nystateofhealth.ny.gov](http://nystateofhealth.ny.gov) or 1-855-355-5777. 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 on how 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: New York State Department of Financial Services at [www.dfs.ny.gov](http://www.dfs.ny.gov) or call 1-800-342-3736. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Community Service Society of New York at [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org) or call 1-888-614-5400.

### 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? Not Applicable

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:

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 1-866-231-0847 (TTY 711).

ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 1-866-231-0847 (TTY 711).

请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 1-866-231-0847 (TTY 711)

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$60</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$30</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$0</b>

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