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.mybcbswny.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/ or call 1-866-231-0847 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your 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. 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 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?	$200	The out-of-pocket limit is the most you could pay in a year for covered services.
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.mybcbswny.com/plans/find-doctors-locations or call 1-866-231-0847 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.

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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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	Please see Subscriber Contract at www.mybcbswny.com/plans/essential-plan for complete detail.
	Specialist visit	No charge	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Please see Subscriber Contract at www.mybcbswny.com/plans/essential-plan for complete detail.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mybcbswny.com/plans/essential-plan	Tier 1 (Generic drugs)	$1 copay/prescription (retail) $2.50 copay/prescription (mail order)	Not covered	Please see Subscriber Contract at www.mybcbswny.com/plans/essential-plan for complete detail.
	Tier 2 (Preferred brand drugs or Formulary brand)	$3 copay/prescription (retail) $7.50 copay/prescription (mail order)	Not covered	
	Tier 3 (Non-preferred brand drugs or Non-formulary brand)	$3 copay/prescription (retail) $7.50 copay/prescription (mail order)	Not covered	
	Specialty drugs	Same as tiered costs above	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Please see Subscriber Contract at www.mybcbswny.com/plans/essential-plan for complete detail.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	None
	Urgent care	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 www.mybcbswny.com/plans/essential-plan 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 www.mybcbswny.com/plans/essential-plan for complete detail.
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Please see Subscriber Contract at www.mybcbswny.com/plans/essential-plan 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	Home health care	No charge	Not covered	40 visit limit
	Rehabilitation services	No change	Not covered	Please see Subscriber Contract at www.mybcbswny.com/plans/essential-plan for complete detail.
	Habilitation services	No charge	Not covered	Please see Subscriber Contract at www.mybcbswny.com/plans/essential-plan for complete detail.
	Skilled nursing care	No charge	Not covered	200 day limit
	Durable medical equipment	No charge	Not covered	Please see Subscriber Contract at www.mybcbswny.com/plans/essential-plan for complete detail.
	Hospice services	No charge	Not covered	210 day limit

* For more information about limitations and exceptions, see the plan or policy document at 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 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
- Cosmetic surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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
- Dental care (Adult)
- Hearing aids (One purchase every three years)
- Infertility treatment
- Routine eye care (Adult)

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 or call 1-866-231-0847, New York State Department of Financial Services at www.dfs.ny.gov or call 1-800-342-3736, Community Service Society of New York at www.communityhealthadvocates.org or call 1-888-614-5400, or NY State of Health: nystateofhealth.ny.gov or 1-855-355-57777. 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 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 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 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.

* For more information about limitations and exceptions, see the plan or policy document at www.mybcbswny.com/plans/essential-plan.

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.

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

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	**$0**
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:	
Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
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**
Specialist copayment	**$0**
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:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
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.