



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 1-877-253-4797 or 1-607-274-2110. 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.excellusbcbcs.com or call 1-877-253-4797 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For out-of-network providers : \$500/ individual or \$1,500/ 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 care services are 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$50/individual for home health care rendered by an out-of-network providers . There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	For participating providers : \$2,000/ individual or \$6,000/ family For out-of-network providers : \$4,000/ individual or \$12,000/ family	The out-of-pocket limit is the most you could pay in a year for covered services. 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 participating provider ?	Yes. See www.excellusbcbcs.com or call 1-877-253-4797 for a list participating 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 a non-participating 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 non-participating 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
		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	\$25 copay /office visit	20% coinsurance	None
	Specialist visit	\$40 copay /office visit	20% coinsurance	None
	Preventive care/screening/immunization	No charge; deductible does not apply	Adult Physical: 20% coinsurance Adult Physical: 20% coinsurance Well Child Visit: no charge	Adult physical exams are limited to one (1) exam per plan year. 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)	Blood work: No charge X-ray: \$40 copay /office visit	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$40 copay /office visit	20% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs (Tier 1)	\$5 copay /prescription (retail) \$10 copay /prescription (mail order)	Not covered	One (1) copay covers up to a 30-day supply (retail prescription); two (2) copays covers up to a 90 day supply (mail order prescription). Specialty drugs filled at retail are limited to a 30-day supply only.
	Preferred brand drugs (Tier 2)	\$35 copay /prescription (retail) \$70 copay /prescription (mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	\$70 copay /prescription (retail) \$140 copay /prescription (mail order)	Not covered	

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)	
	Specialty drugs	Same as the retail or mail order copay listed above depending on if it is Tier 1, Tier 2 or Tier 3 drug	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copay	20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	\$150 copay /visit	\$150 copay /visit; deductible does not apply	None
	Emergency medical transportation	\$150 copay /visit	\$150 copay /visit; deductible does not apply	
	Urgent care	\$40 copay /visit	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay	20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay /visit	20% coinsurance	None
	Inpatient services	\$250 copay	20% coinsurance	
If you are pregnant	Office visits	No charge	20% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance, copayment, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	\$250 copay	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	None.
	Rehabilitation services	\$40 copay /visit	20% coinsurance	Limited to 45 visits per plan year.
	Habilitation services	\$40 copay /visit	20% coinsurance	
	Skilled nursing care	\$250 copay	20% coinsurance	Limited to 45 visits per plan year.

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)	
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice services	No charge	20% coinsurance	Family bereavement counseling is limited to five (5) visits per plan year.
If your child needs dental or eye care	Children's eye exam	\$40 copay /visit	20% coinsurance	Limited to one (1) exam per plan year.
	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 .)			
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult and Child) 	<ul style="list-style-type: none"> • Hearing aids • Long-term care 	<ul style="list-style-type: none"> • 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.)			
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Chiropractic care 	<ul style="list-style-type: none"> • Infertility treatment • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or 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 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: www.excellusbcbcs.com or call 1-877-253-4797 or call Ithaca City School District at 1-607-274-2110. You may also contact the 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 Community Service Society of New York, Community Health Advocates, 633 Third Avenue, 10th floor, New York, NY 10017, (888) 614-5400, <http://www.communityhealthadvocates.org/> (website), cha@cssny.org (email). A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-253-4797.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-253-4797.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-253-4797.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-253-4797.

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](#) \$40
- Hospital (facility) [copayment](#) \$250
- Other [coinsurance](#) 20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$860

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](#) \$40
- Hospital (facility) [copayment](#) \$250
- Other [coinsurance](#) 20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$720

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$250
- Other [coinsurance](#) 20%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles *	\$0
Copayments	\$900
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$950

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