Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

RASHP II - Value

Excellus BCBS: BluePoint2

Coverage Period: 01/01/2021 - 12/31/2021

A nonprofit independent licensee of the BlueCross BlueShield Association

Coverage for: Family | **Plan Type:** POS

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 1-800-499-1275 or visit Our website at www.excellusbcbs.com. 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.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Out-of-Network: $750 Individual/$1,500 Two Person/$2,250 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	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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,200 Individual/$8,400 Two Person/ $12,600 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?	Costs for penalties for failure to obtain preauthorization for services, 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.excellusbcbs.com or call 1-800-499-1275 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
		In-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	$20 Copay/visit	20% Coinsurance	None
	Specialist visit	$20 Copay/visit	20% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge	Adult Physical: Not Covered Adult Immunizations: Not Covered Well Child Visit: 20% Coinsurance	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. 1 Exam per year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: $20 Copay/visit Blood Work: No Charge	X-Ray: 20% Coinsurance Blood Work: 20% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	$20 Copay/visit	20% Coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.excellusbcbs.com/rxlist	Tier 1 (Generic drugs)	$10/prescription retail, $30/ prescription mail order	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription Preauthorization required for certain prescription drugs. If you don't get a preauthorization, you must pay the entire cost of the drug.
	Tier 2 (Preferred brand drugs)	$25/prescription retail, $75/ prescription mail order	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$40/prescription retail, $120/ prescription mail order	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 Copay	20% Coinsurance	None
	Physician/surgeon fees	$20/surgery Copay	20% Coinsurance	
If you need immediate medical attention	Emergency room care	$50 Copay/visit	$50 Copay/visit	None
	Emergency medical transportation	$50 Copay/visit	$50 Copay/visit Deductible does not apply	None
	Urgent care	$25 Copay/visit	$25 Copay/visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copay	20% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	20% Coinsurance	

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 Copay/visit	20% Coinsurance	None
	Inpatient services	$100 Copay	20% Coinsurance	
If you are pregnant	Office visits	No Charge	20% Coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% Coinsurance	20% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery facility services	$100 Copay	20% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	No Charge	20% Coinsurance	Deductible is limited to $50 Out-of-Network
	Rehabilitation services	$20 Copay/visit	20% Coinsurance	30 Visits per year limit
	Habilitation services	$20 Copay/visit	20% Coinsurance	30 Visits per year limit
	Skilled nursing care	$100 Copay	20% Coinsurance	120 Days per year limit
	Durable medical equipment	20% Coinsurance	Not Covered	None
	Hospice services	No Charge	20% Coinsurance	Family bereavement counseling limited to 5 Visits per year
If your child needs dental or eye care	Children's eye exam	$20 Copay/visit	Not Covered	1 Exam per calendar year
	Children's glasses	20% Coinsurance	Not Covered	1 Pair per calendar year
	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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

• Hearing aids	• 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: 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: the phone number on Your ID card or www.excellusbcbs.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; 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 the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and 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?

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.

––––––––––––––––––––––To see examples of how this plan might cover costs for a sample medical situation, see the next section.––––––––––––––––––––

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

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**
Copayment	**$20**
Hospital (facility) copayment	**$100**
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$240
Coinsurance	$520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$820**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$0**
Copayment	**$20**
Hospital (facility) copayment	**$100**
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$950
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$970**

Mia's Simple Fracture

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

The plan's overall deductible	**$0**
Copayment	**$20**
Hospital (facility) copayment	**$100**
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$250**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.