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 Excellus BlueCross BlueShield at 1-800-370-5421 or call Cayuga-Onondaga Area School Employee Healthcare Plan at 1-315-253-0361. or 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.excellusbcbs.com or call 1-800-370-5421 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 individual/$600 family Applies to major medical benefits only.	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. Office visits, some preventive care, diagnostic tests and imaging, outpatient surgery, inpatient hospital, mental health and substance use services, maternity care, home health care, rehabilitation services, skilled nursing care, hospice services and emergency 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.
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?	$650 individual/$1,950 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 premiums, balance-billing charges, deductible, copayments, 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 1-800-370-5421 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
		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	$15 copayment/ visit, deductible does not apply	$15 copayment/ visit, deductible does not apply	None
	Specialist visit	$15 copayment/ visit, deductible does not apply	$15 copayment/ visit, deductible does not apply	None
	Preventive care/screening/ immunization	$15 copayment, deductible does not apply Adult immunizations: Not covered	$15 copayment, deductible does not apply Adult immunizations: 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)	$15 copayment, deductible does not apply	$15 copayment, deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	$15 copayment, deductible does not apply	$15 copayment, deductible does not apply	
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)	20% coinsurance, deductible does not apply		Contact Express Scripts for prescription drug coverage inquiries. The Express Scripts contact information is located on your Benefit Identification Card.
	Preferred brand drugs (Tier 2)	25% coinsurance, deductible does not apply		
	Non-preferred brand drugs (Tier 3)	30% coinsurance, deductible does not apply		
	Specialty drugs	20% coinsurance (Tier 1) 25% coinsurance (Tier 2) 30% coinsurance (Tier 3) Deductible does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copayment/ visit, deductible does not apply	$50 copayment/ visit, deductible does not apply	None

* For more information about limitations and exceptions, see the plan or policy document at the Cayuga-Onondaga Area School website: https://www.cayboces.org.

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)	
	Physician/surgeon fees	$50 copayment/ occurrence, deductible does not apply	$50 copayment/ occurrence, deductible does not apply	None
If you need immediate medical attention	Emergency room care	$35 copayment/ visit, deductible does not apply	$35 copayment/ visit, deductible does not apply	Emergency room copayment waived if admitted to the hospital.
	Emergency medical transportation	$35 copayment, deductible does not apply	$35 copayment, deductible does not apply	None
	Urgent care	$35 copayment, deductible does not apply	$35 copayment, deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment, deductible does not apply	$250 copayment, deductible does not apply	None
	Physician/surgeon fees	$50 copayment, deductible does not apply	$50 copayment, deductible does not apply	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copayment, deductible does not apply	$15 copayment, deductible does not apply	None
	Inpatient services	$250 copayment, deductible does not apply	$250 copayment, deductible does not apply	
If you are pregnant	Office visits	$15 copayment/ initial visit, deductible does not apply	$15 copayment/ initial , deductible does not apply visit	None
	Childbirth/delivery professional services	No charge, deductible does not apply	No charge, deductible does not apply	
	Childbirth/delivery facility services	$250 copayment, deductible does not apply	$250 copayment, deductible does not apply	

* For more information about limitations and exceptions, see the plan or policy document at the Cayuga-Onondaga Area School website: https://www.cayboces.org.

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 need help recovering or have other special health needs	Home health care	No charge, deductible does not apply	No charge, deductible does not apply	Limited to 40 visits per calendar year.
	Rehabilitation services	$15 copayment/ visit, deductible does not apply	$15 copayment/ visit, deductible does not apply	Includes physical, occupational and speech therapy. Speech therapy is limited to 30 days per calendar year. This limit is combined with respiratory therapy.
	Habilitation services	$15 copayment/ visit, deductible does not apply	$15 copayment/ visit, deductible does not apply	
	Skilled nursing care	No charge, deductible does not apply	No charge, deductible does not apply	Limited to 100 days per calendar year.
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice services	No charge, deductible does not apply	No charge, deductible does not apply	None
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.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Hearing aids
- Long-term care
- Routine eye care (Adult & Child)
- 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 (Limited to 15 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (inpatient is not covered)

* For more information about limitations and exceptions, see the plan or policy document at the Cayuga-Onondaga Area School website: https://www.cayboces.org.

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: the 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.excellusbcbs.com or call 1-800-370-5421 or call Cayuga-Onondaga Area School at 1-315-253-0361. 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 1-800-370-5421.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-5421.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-370-5421.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-370-5421.

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 the plan or policy document at the Cayuga-Onondaga Area School website: https://www.cayboces.org.

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	$200
Specialist copayment	$15
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$10
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$670**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$200
Specialist copayment	$15
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$300
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$200
Specialist copayment	$15
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$400
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$610**

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