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, go to www.mybensite.com/ccsd or call 386-2375. 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 http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call (716) 386-2375 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $0; for out-of-network providers $250 individual /$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, network providers services and prescription drugs are not subject to a 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $6,600 individual / $13,200 family; for out-of-network providers $2,000 individual / $4,000 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 network provider?	Yes. See www.bcbswny.com or call 1-888-839-5169 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 in-network specialist you choose without permission from this plan

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	$10 copayment	20% coinsurance	None
	Specialist visit	$10 copayment	20% coinsurance	None
	Preventive care/screening/ immunization	Covered in full	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Flu vaccine covered in full out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	Covered in full for blood work, $10 copayment for x-ray	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$10 copayment	20% coinsurance	Prior authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at (716) 386-2375	Generic drugs (Tier 1)	$10 copayment	$10 copayment	Some generic drugs may be subject to non-preferred brand copayment. Specialty drugs could be generic, preferred brand, or non-preferred brand. Please visit www.bcbswny.com for a copy of the medication guide. For out-of-network providers, member pays 100% at the point of sale and will be reimbursed by BlueCross BlueShield of WNY.
	Preferred brand drugs (Tier 2)	$20 copayment	$20 copayment	
	Non-preferred brand drugs (Tier 3)	$20 copayment	$20 copayment	
	Specialty drugs (Tier 4)	See Limitations & Exceptions	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered in full	20% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
	Physician/surgeon fees	Covered in full	20% coinsurance	Prior authorization required on certain procedures. Call the number on the back of your ID card for details.
If you need immediate medical attention	Emergency room care	$50 copayment	$50 copayment	None
	Emergency medical transportation	$50 copayment	$50 copayment	
	Urgent care	$10 copayment	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered in full	20% coinsurance	Prior authorization required.
	Physician/surgeon fees	Covered in full	20% coinsurance	None

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 mental health, behavioral health, or substance abuse services	Outpatient services	$10 copayment for Mental Health $10 copayment for Substance Abuse	20% coinsurance for Mental Health 20% coinsurance for Substance Abuse	None
	Inpatient services	Covered in full for Inpatient Mental Health Covered in full for Substance Abuse detox Covered in full for Substance Abuse rehab	20% coinsurance for Mental Health 20% coinsurance for Substance Abuse detox 20% coinsurance for Substance Abuse Rehab	Prior authorization required.
If you are pregnant	Office visits	$10 copayment	20% coinsurance	For network providers, copayment applies only to initial visit to determine pregnancy. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Covered in full	20% coinsurance	None
	Childbirth/delivery facility services	Covered in full	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	$10 copayment	20% coinsurance	None
	Rehabilitation services	$10 copayment	20% coinsurance	20 visits per year. Includes physical therapy, occupational therapy,and speech therapy.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	Covered in full	20% coinsurance	Prior authorization required. 50 days per year.
	Durable medical equipment	50% coinsurance	50% coinsurance	Prior authorization required on certain equipment. Call the number on the back of your ID card for details.
	Hospice services	Covered in full	20% coinsurance	210 days maximum
If your child needs dental or eye care	Children's eye exam	$10 copayment	20% coinsurance	Covered in full for 1 routine per year for children under age 5
	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
- Custodial Care
- Dental (Adult)
- Habilitation Services
- Hearing aids
- Routine foot care
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric Surgery
- Chiropractic Care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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 are the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services 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 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: 1-888-839-5169.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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 1-888-249-2583.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-249-2583.
[Chinese (中文): 如果需要中文的帮助，□□□□□□□ 1-888-249-2583.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-249-2583.

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	$10
Hospital (facility) copayment	$0
Other copayment	$10

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$130**

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	$10
Hospital (facility) copayment	$0
Other copayment	$10

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$670
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$730**

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

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) copayment	$0
Other copayment	$10

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$240
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$260**

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