Not Just Coverage. Confidence.

Your Benefit Plan Details

Group Name
Oak Orchard Health

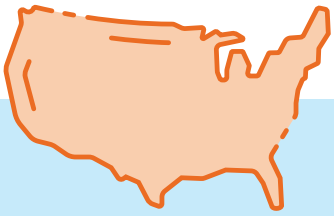
Excellus BlueCross BlueShield

Everybody Benefits

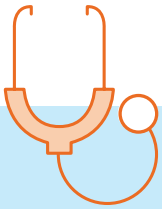
Welcome to Excellus BlueCross BlueShield!

Getting the most from your health plan is more important than ever. Excellus BCBS is here to bring together the coverage, programs and resources you need to be on your way to total physical, emotional and financial wellbeing.

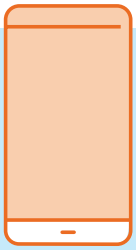
You can count on your Excellus BCBS plan for care when and where you need it:



The area's **largest network of doctors and hospitals,** with greater access close to home and in all 50 states



$0 copays for most preventive services such as an annual routine physical exam*, select vaccines, and important health screenings



Free digital support tools for answers anytime, anywhere, such as:

- Online member account
- Mobile app
- Estimate out-of-pocket medical costs
- Find a doctor, specialist or facility that accepts your plan

Find more answers and support at **ExcellusBCBS.com**

In this booklet you will find:

- A chart that summarizes this plan's unique benefits and coverage**
- Helpful information to help you get the most from your plan
- A glossary of terms to help you understand your coverage and options

* Does not include procedures, injections, diagnostic services, laboratory and X-ray services, or any other services not billed as preventive services.
**This benefit summary is not a contract or binding agreement; it is a summary of benefits and services.

Oak Orchard Health

Copay $30

Plan Features

Primary Care Physician (PCP)	Not Required
Referrals	Not Required
Out of network benefits	Covered
Student / Dependent Coverage	Covered to age 26
Domestic Partner	Covered
Coverage Period	01/01/24-12/31/24
Office visit copay (Primary Care Physician)	$30 in-network / 20% out-of-network
Office visit copay (Specialist)	$50 in-network / 20% out-of-network
Coinsurance	0% in-network / 20% out-of-network
Deductible	$0 in-network / $500/$1,500 out-of-network
Out of pocket maximum	$6,000/$18,000 in-network / $12,000/$36,000 out-of-network

Questions? For assistance call ,
Call our TTYphone at 1 (800) 421-1220,

Excellus

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: $500 Individual/$1,000 Two Person/$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	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?	In-Network: $6,000 Individual/$12,000 Two Person/$18,000 Family; Out-of-Network: $12,000 Individual/$24,000 Two Person/ $36,000 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?	Costs for 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	$30 Copay/visit	20% Coinsurance	None
	Specialist visit	$50 Copay/visit	20% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge	Adult Physical: 20% Coinsurance Adult Immunizations: 20% Coinsurance Well Child Visit: No Charge	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 calendar year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: $50 Copay/visit Blood Work: No Charge	X-Ray: 20% Coinsurance Blood Work: 20% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	$50 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)	$5/prescription retail, $10/ prescription mail order No Charge Members to age 19		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 and submit a claim to us for reimbursement.
	Tier 2 (Preferred brand drugs)	$25/prescription retail, $50/ prescription mail order	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$50/prescription retail, $100/ prescription mail order	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	
If you need immediate medical attention	Emergency room care	$100 Copay/visit	$100 Copay/visit	None
	Emergency medical transportation	$100 Copay/visit	$100 Copay/visit Deductible does not apply	None
	Urgent care	$75 Copay/visit	20% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 Copay	20% Coinsurance	None
	Physician/surgeon fees	No Charge	20% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay/visit	20% Coinsurance	None
	Inpatient services	$500 Copay	20% Coinsurance	
If you are pregnant	Office visits	No Charge	20% Coinsurance	Cost sharing does not apply for preventive services.

* 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)	
	Childbirth/delivery professional services	No Charge	20% Coinsurance	None
	Childbirth/delivery facility services	$500 Copay	20% Coinsurance	
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	$50 Copay/visit	20% Coinsurance	45 Visits per plan year limit
	Habilitation services	$50 Copay/visit	20% Coinsurance	45 Visits per plan year limit
	Skilled nursing care	$500 Copay	20% Coinsurance	45 Days per plan year limit
	Durable medical equipment	20% Coinsurance	20% Coinsurance	None
	Hospice services	No Charge	20% Coinsurance	Family bereavement counseling limited to 5 Visits per plan year
If your child needs dental or eye care	Children's eye exam	No Charge	20% Coinsurance	1 Exam per contract year
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	

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
- Dental care (Adult)
- Dental care (Child)
- Long-term care
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- 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 https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. 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/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; New York State Department of Financial Services Consumer Assistance Unit at

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

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: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc 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? **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.

––––––––––––––––––––––*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	$50
Hospital (facility) copayment	$500
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	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,160**

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	$50
Hospital (facility) copayment	$500
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	$1,270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,290**

Mia's Simple Fracture

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

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) copayment	$500
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	$450
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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

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Excellus BluePPO Signature Copay 1

$5/$25/$50 $0 Generics for Kids

Benefit Time Period: 01/01/2024 - 12/31/2024

Oak Orchard Health

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$0	$500	
Deductible - Family	$0	$1,500	Each individual does not exceed the single deductible.
Coinsurance	0%	20%	
Annual Out of Pocket Maximum - Single	$6,000	$12,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$18,000	$36,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	$30 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	$50 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Sick Kids	$0 Copayment	20% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Plan Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	$500 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	$500 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	$500 Copayment	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$500 Copayment	20% Coinsurance Subject to Deductible	45 Days per plan year Limits are combined INN and OON.
Physical Rehabilitation	$500 Copayment	20% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
Maternity Care	$500 Copayment	20% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	Covered in Full	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	$150 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	$50 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	$50 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	$30 Copayment	20% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	$30 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	$30 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	Covered in Full	20% Coinsurance Subject to $50 Deductible	
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to $50 Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	Covered in Full	20% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP - $30 Copayment Specialist - $50 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - $50 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - $50 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - $30 Copayment	20% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $30 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	$0 Kids Copay applies to PCP and Specialist
Maternity Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Telehealth	PCP - $30 Copayment Specialist - $50 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - Covered in Full $0 PCP Copay for members to age 19.	Not Covered	Covers online internet consultations between the member and the providers who participate in our Telemedicine MDLive and Vori Health Program for medical, behavioral health, and physical therapy conditions that are not emergency conditions.
Chiropractic Care	PCP/Specialist - $30 Copayment	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP - $30 Copayment Specialist - $50 Copayment $0 PCP Copay for members to age 19.	20% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - $50 Copayment	20% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	$50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - $50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - $50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - $50 Copayment	20% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per calendar year
Adult Immunizations	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - $50 Copayment	20% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$50 Copayment	20% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - $30 Copayment	20% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - $30 Copayment	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Covered	Covered	$4,000 Reimbursement Per Plan Year Reimbursement is available for travel and lodging to another state to access covered services when access to covered services is not available due to a law or regulation in the state where the member resides.

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	$100 Copayment	$100 Copayment	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	$100 Copayment	$100 Copayment	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	$75 Copayment	20% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Covered in Full	20% Coinsurance Subject to Deductible	1 Exam per contract year
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	$50 Copayment	20% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$5/$25/$50 $0 Generics for Kids

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	2		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

Oak Orchard Health

HDHP $2,000

Plan Features

Primary Care Physician (PCP)	Not Required
Referrals	Not Required
Out of network benefits	Covered
Student / Dependent Coverage	Covered to age 26
Domestic Partner	Covered
Coverage Period	01/01/24-12/31/24
Office visit copay (Primary Care Physician)	20% in-network / 40% out-of-network
Office visit copay (Specialist)	20% in-network / 40% out-of-network
Coinsurance	20% in-network / 40% out-of-network
Deductible	$2,000/$4,000 in-network / $4,000/$8,000 out-of-network
Out of pocket maximum	$4,000/$8,000 in-network / $8,000/$16,000 out-of-network

Questions? For assistance call ,
Call our TTYphone at 1 (800) 421-1220,

Excellus

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?	In-Network: $2,000 Individual/ $4,000 Family; Out-of-Network: $4,000 Individual/ $8,000 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 policy, the overall family deductible must be met before the plan begins to pay.
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?	In-Network: $4,000 Individual/$8,000 Family; Out-of-Network: $8,000 Individual/ $16,000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Costs for 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% Coinsurance	40% Coinsurance	None
	Specialist visit	20% Coinsurance	40% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: 40% Coinsurance Adult Immunizations: 40% Coinsurance Well Child Visit: No Charge	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 calendar year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: 20% Coinsurance Blood Work: 20% Coinsurance	X-Ray: 40% Coinsurance Blood Work: 40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% 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)	$5/prescription retail, $10/ prescription mail order No Charge Members to age 19		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 and submit a claim to us for reimbursement.
	Tier 2 (Preferred brand drugs)	$35/prescription retail, $70/ prescription mail order	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$70/prescription retail, $140/ prescription mail order	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	40% Coinsurance	None
	Inpatient services	20% Coinsurance	40% Coinsurance	
If you are pregnant	Office visits	No Charge	40% Coinsurance	Cost sharing does not apply for preventive services.

* 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)	
	Childbirth/delivery professional services	20% Coinsurance	40% 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	20% Coinsurance	40% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	None
	Rehabilitation services	20% Coinsurance	40% Coinsurance	45 Visits per plan year limit
	Habilitation services	20% Coinsurance	40% Coinsurance	45 Visits per plan year limit
	Skilled nursing care	20% Coinsurance	40% Coinsurance	45 Days per plan year limit
	Durable medical equipment	20% Coinsurance	40% Coinsurance	None
	Hospice services	20% Coinsurance	40% Coinsurance	Family bereavement counseling limited to 5 Visits per plan year
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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
- Dental care (Adult)
- Dental care (Child)
- Long-term care
- Private-duty nursing
- Routine eye care (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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- 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 https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. 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/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; 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: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc 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? **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.

––––––––––––––––––––––*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	**$2,000**
Coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
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	$2,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$2,000**
Coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
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	$2,000
Copayments	$50
Coinsurance	$670
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,740**

Mia's Simple Fracture

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

The plan's overall deductible	**$2,000**
Coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
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	$2,000
Copayments	$0
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,160**

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

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Excellus BluePPO Signature Deduct 3

$5/$35/$70 Integrated Rx $0 Generics for Kids Preventive Rx not subject to Deductible

Benefit Time Period: 01/01/2024 - 12/31/2024

Oak Orchard Health

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$2,000	$4,000	
Deductible - Family	$4,000	$8,000	
Coinsurance	20%	40%	
Annual Out of Pocket Maximum - Single	$4,000	$8,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$8,000	$16,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Plan Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per plan year Limits are combined INN and OON.
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
Maternity Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $2,000 Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Home Infusion Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - 0% Coinsurance Subject to Deductible	Not Covered	Covers online internet consultations between the member and the providers who participate in our Telemedicine MDLive and Vori Health Program for medical, behavioral health, and physical therapy conditions that are not emergency conditions.
Chiropractic Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per calendar year
Adult Immunizations	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. Limited to no more than $100 member cost-share (including before the Deductible) for a 30-day supply of insulin.
Diabetic Equipment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Medical Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Covered Subject to Deductible	Covered Subject to $2,000 Deductible	$4,000 Reimbursement Per Plan Year Reimbursement is available for travel and lodging to another state to access covered services when access to covered services is not available due to a law or regulation in the state where the member resides.

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $2,000 Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $2,000 Deductible	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$5/$35/$70 Integrated Rx $0 Generics for Kids Preventive Rx not subject to Deductible

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
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Oak Orchard Health

HDHP $4,000

Plan Features

Primary Care Physician (PCP)	Not Required
Referrals	Not Required
Out of network benefits	Covered
Student / Dependent Coverage	Covered to age 26
Domestic Partner	Covered
Coverage Period	01/01/24-12/31/24
Office visit copay (Primary Care Physician)	0% in-network / 0% out-of-network
Office visit copay (Specialist)	0% in-network / 0% out-of-network
Coinsurance	0% in-network / 0% out-of-network
Deductible	$4,000/$8,000 in-network / $8,000/$16,000 out-of-network
Out of pocket maximum	$4,000/$8,000 in-network / $8,000/$16,000 out-of-network

Questions? For assistance call ,
Call our TTYphone at 1 (800) 421-1220,

Excellus

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?	In-Network: $4,000 Individual/ $8,000 Family; Out-of-Network: $8,000 Individual/ $16,000 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 policy, the overall family deductible must be met before the plan begins to pay.
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?	In-Network: $4,000 Individual/$8,000 Family; Out-of-Network: $8,000 Individual/ $16,000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Costs for 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	No Charge	No Charge	None
	Specialist visit	No Charge	No Charge	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge	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 calendar year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: No Charge Blood Work: No Charge	X-Ray: No Charge Blood Work: No Charge	None
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	
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)	No Charge		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 and submit a claim to us for reimbursement.
	Tier 2 (Preferred brand drugs)	No Charge	Not Covered	
	Tier 3 (Non-preferred brand drugs)	No Charge	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	
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	No Charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	No Charge	None
	Inpatient services	No Charge	No Charge	
If you are pregnant	Office visits	No Charge	No Charge	Cost sharing does not apply for preventive services.

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)	
	Childbirth/delivery professional services	No Charge	No Charge	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	No Charge	No Charge	None
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	None
	Rehabilitation services	No Charge	No Charge	45 Visits per plan year limit
	Habilitation services	No Charge	No Charge	45 Visits per plan year limit
	Skilled nursing care	No Charge	No Charge	45 Days per plan year limit
	Durable medical equipment	No Charge	No Charge	None
	Hospice services	No Charge	No Charge	Family bereavement counseling limited to 5 Visits per plan year
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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
- Dental care (Adult)
- Dental care (Child)
- Long-term care
- Private-duty nursing
- Routine eye care (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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- 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 https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. 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/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; 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: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc 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? **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.

––––––––––––––––––––––*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	**$4,000**
Coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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	$4,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$4,000**
Coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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	$4,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,020**

Mia's Simple Fracture

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

The plan's overall deductible	**$4,000**
Coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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 (This condition is not covered, so patient pays 100%):

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

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Excellus BluePPO Signature Deduct 3

Covered in Full Integrated Rx with $5/$35/$70 Preventive Rx $0 Generics for Kids

Benefit Time Period: 01/01/2024 - 12/31/2024

Oak Orchard Health

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$4,000	$8,000	
Deductible - Family	$8,000	$16,000	
Coinsurance	0%	0%	
Annual Out of Pocket Maximum - Single	$4,000	$8,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$8,000	$16,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Cost Share - Specialist	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Plan Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Services	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Mental Health Care	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Substance Use Detoxification	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Skilled Nursing Facility	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Days per plan year Limits are combined INN and OON.
Physical Rehabilitation	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
Maternity Care	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Inpatient Hospital Surgery	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to $4,000 Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Diagnostic X-ray	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Radiation Therapy	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Chemotherapy	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Mental Health Care	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Home Infusion Therapy	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	Services must be ordered by a Physician/ authorized Health Care Professional and provided by an agency or office licensed/ certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - 0% Coinsurance Subject to Deductible	Not Covered	Covers online internet consultations between the member and the providers who participate in our Telemedicine MDLive and Vori Health Program for medical, behavioral health, and physical therapy conditions that are not emergency conditions.
Chiropractic Care	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Occupational Rehabilitation	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.
Speech Rehabilitation	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per plan year Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Adult Physical Examination	PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	1 Exam per calendar year
Adult Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cervical Cytology Preventative	Covered in Full	0% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	0% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	0% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	0% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	0% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	0% Coinsurance Subject to Deductible	
Bone Density Screening Facility	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy. Limited to no more than $100 member cost-share (including before the Deductible) for a 30-day supply of insulin.
Diabetic Equipment	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Medical Supplies	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Covered Subject to Deductible	Covered Subject to $4,000 Deductible	$4,000 Reimbursement Per Plan Year Reimbursement is available for travel and lodging to another state to access covered services when access to covered services is not available due to a law or regulation in the state where the member resides.

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to $4,000 Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to $4,000 Deductible	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	1 Exam per contract year
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			Covered in Full Integrated Rx with $5/$35/$70 Preventive Rx $0 Generics for Kids

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	2		

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.

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SIGNING UP IS AS EASY AS 1, 2, 3

STEP 1

Call a pharmacy

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STEP 2

Speak to a representative

STEP 3

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Call today!

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B-6342/17934-23Rx REV 07/23

Manage your overall wellbeing with one simple tool

Headspace, integrated with Virgin Pulse, is the preferred mindfulness and meditation partner of Excellus BlueCross BlueShield. Now, we're proud to include it with your plan.

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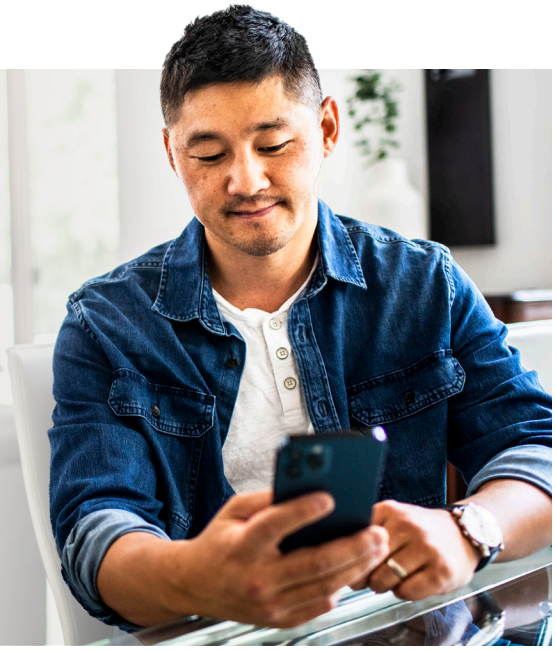

Headspace for work and home

The power to create lasting change in your happiness, mindfulness, and productivity is officially right in your hands. With the Headspace science-based app, you get hundreds of meditations and exercises for stress, focus, sleep, and movement – and our partnership with Virgin Pulse provides you curated access to it all. Headspace will help you gain greater insight into your health and wellbeing than ever before, all while building healthy habits along the way.

Virgin pulse

- Learn to manage feelings and thoughts with everyday mindfulness
- Sleep better with sleepcasts, music, and other unique audio experiences
- Get moving with exercises to strengthen your mental and physical wellbeing
- Boost focus with music and meditations
- Start your morning right with inspiring stories

Users reported:

REDUCED STRESS

32%

less stress after 30 days of Headspace[1]

IMPROVED FOCUS

22%

less mind-wandering after one session of Headspace[2]

DECREASED DEPRESSION AND ANXIETY SYMPTOMS

29%

decrease in depressive symptoms after eight weeks of Headspace[3]

19%

decrease in anxiety symptoms after eight weeks of Headspace[3]

Headspace is included with your health plan. Log in to your member account to get started.
Member.ExcellusBCBS.com

1 Headspace peer-reviewed paper in PLOS One
2 Department of Psychology, University of Southern Denmark
3 Headspace peer-reviewed paper in American Psychological Association

Subject to DFS approval
Virgin Pulse is a separate company and offers a digital wellbeing service on behalf of Excellus BCBS.

B-8366

PEACE OF MIND. FREE OF CHARGE.

SCHEDULE YOUR ANNUAL CHECKUP TODAY

Stay a step ahead of future health issues by staying on top of your routine checkups today.

✓ PREVENTIVE CARE KEEPS YOU HEALTHY. AND IT'S COVERED.*

- Annual Routine Checkup
- Annual OB/GYN Visit
- Cholesterol Screening
- Colorectal Cancer Screening
- Diabetes (Type 2) Screening
- Immunizations
- Mammography Screening
- Well-Child Visit

See the full list of preventive care services available to you at
ExcellusBCBS.com/PreventiveCare

Download the Excellus BCBS app and register your online account.

Download on the App Store | GET IT ON Google Play

*A well visit or preventive service can sometimes turn into a "sick visit," in which out-of-pocket expenses for deductible, copay and/or coinsurance may apply. There may also be other services performed in conjunction with the above preventive care services that might be subject to deductible, copay and/or coinsurance. Does not include procedures, injections, diagnostic services, laboratory and X-ray services, or any other services not billed as preventive services.

B-7332/15926-22M

Telemedicine for Medical and Behavioral Health Care

THE DOCTOR WILL SEE YOU NOW. WHEREVER. WHENEVER.

If your doctor isn't available, telemedicine may be an option for you. Telemedicine gives you fast access to medical and behavioral health care 24/7/365, from the comfort of your home, desk, or hotel room. **All you need to do is activate it through your online member account and download the MDLIVE app.**

Rest assured, our health care professionals deliver the same quality of care you receive from your own doctor, via your phone, tablet, or computer.

When do you use telemedicine?

- Instead of going to urgent care or the emergency room for minor and non-life-threatening conditions
- Whenever your primary care doctor is not available
- If you live in a rural area and don't have access to nearby care
- When you're traveling for work or on vacation

Here are some of the common medical conditions treated with telemedicine:

Adults

- Allergies
- Cold and Flu
- Ear Infections
- Fever
- Headache
- Joint Aches and Pains
- Nausea and Vomiting
- Pink Eye
- Rashes
- Sinus Infections
- Sunburn
- Urinary Tract Infections*

Children

- Cold and Flu
- Constipation
- Earache*
- Fever*
- Nausea and Vomiting
- Pink Eye

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*MDLIVE does not provide support for urinary tract infections in males; does not provide support for earache conditions for children under 12 years old; does not provide support for fever-related conditions for children under 3 years old.

Telemedicine is good for the mind as well as the body.

In addition to whenever, wherever access to medical doctors, you can also consult with a psychiatrist or choose from a variety of licensed therapists from the privacy of your own home. You can even schedule recurring appointments to establish an ongoing relationship with one therapist.

Here are some conditions people rely on behavioral health telemedicine for:

- Addiction
- Bipolar Disorders
- Depression
- Eating Disorders
- Grief and Loss
- LGBTQ Support
- Panic Disorders
- Stress
- Trauma and PTSD

Telemedicine visits with MDLIVE may be covered in the following ways:

Plan Type	Telemedicine Cost Share
Copay	Covered in full
Hybrid / Deductible Non-HSA	If your doctor's visits are subject to deductible, a telemedicine visit will be covered in full after deductible
	If your doctor's visits are a copay with no deductible, a telemedicine visit will be covered in full
Deductible HSA	Covered in full after deductible
Note: This is not a contract. It is intended to highlight the coverage for most plan options. Please refer to your contract for your plan's benefits.	

*If you haven't met your deductible, you will pay the allowable charge of $50. The allowable charge does not apply to Behavioral Health services. The allowable costs for the Behavioral Health services vary but do not exceed $180. This means a member who has not met their deductible will not pay more than $180.

Don't wait until you need it. There are four easy ways to activate telemedicine today.

WEB - Register/Log in at ExcellusBCBS.com/Member
APP - Download the MDLIVE app
TEXT - EXCELLUS to 635483 (Message and data rates may apply.)
VOICE - Call 1-866-692-5045

DID YOU KNOW?

of doctor's office visits could be handled over the phone.[1]

days is the average wait time between scheduling an appointment and seeing a primary care doctor.[2]

of emergency room visits can potentially be prevented with telemedicine.[3]

[1] "New medical cost savings program: Telemedicine means great discounts." R. Schultz, January 9, 2010.

[2] Based on MDLIVE data, 2016.

[3] Based on New York State Department of Health data, 2016.

MDLIVE does not replace the primary care physician. MDLIVE is not an insurance product. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services. MDLIVE phone consultations are available 24/7/365, while video consultations are available during the hours of 7 am to 9 pm ET 7 days a week or by scheduled availability. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use and privacy policy, please visit www.mdlive.com/terms-of-use and www.mdlive.com/privacy-policy. MDLIVE is an independent company, offering telehealth services in the Excellus BlueCross BlueShield service area.

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, origin, age, disability, or sex.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意 ：如果您说中文 ，我们可为您提供免费的语言协助 。请参见随附的文件以获取我们的联系方式 。

B-6675 / 17633-23M REV 04/23

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ThriveWell℠ powered by Virgin Pulse

WELLBEING FOR ALL, ALL IN ONE PLACE

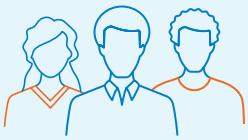
Introducing ThriveWell, a digital home base for your health and wellbeing. Our partnership with Virgin Pulse will give you the tools and support you need to make small, everyday changes to your wellbeing that are focused on the areas you want to improve the most. You'll build healthy habits, have fun with friends and experience the lifelong rewards of better health and wellbeing.

Within ThriveWell, you can:

Connect a fitness tracker so you can log your activity and watch for small improvements over time.

Set your interests by choosing to work on an area that matters the most to you, like eating habits, sleep, physical activity, relationships or finances.

See a clear picture of your health with a certified Health Risk Assessment (Health Check).



Add friends and family, connecting with up to 10 others to help encourage and motivate one another.

Rally coworkers for the latest company step challenge! Or gather a small group of coworkers or friends, and challenge one another to start a new healthy habit.

Use the digital coaching tool to make simple changes to your health, one small step at a time.

ThriveWell is now included with your health plan. Log into your member account to get started. Member.ExcellusBCBS.com

B-8371

Health Plan Terms

To help you better understand our plans and your coverage, here are a few definitions* for frequently used health care terms.

Primary Care Physician (PCP)

A doctor who serves as your health care manager and coordinates virtually all of the health care services you routinely receive. Some plans do not require you to choose a PCP.

Referral

Instructions provided by a PCP for specialty care. Most plans do not require referrals.

In-network coverage

The coverage available when you receive services from a provider who participates in your health plan.

Out-of-network coverage

The coverage available when you receive services from a provider who does not participate in your health plan. Some plans may not include out-of-network coverage.

Out-of-area

Describes when you receive services while outside the geographic service area of your health plan. Your plan benefits may differ if you live or work beyond the geographic service area.

Copay

A dollar amount due at the time you receive certain services. A typical example would be an office visit copay due when visiting your physician's office for treatment.

Allowed Amount

The maximum amount your health plan will pay for a specific service. In-network providers agree to accept the allowed amount as payment in full.

Coinsurance

A cost-sharing method that requires you pay a percentage of the allowed amount for certain medical services.

Deductible

A set dollar amount you pay for services you receive before your insurer will make a payment.

Out-of-pocket maximum

The maximum amount of copays, deductible and coinsurance payments that you will pay for health services each calendar year.

*Some definitions may vary slightly by plan. In case of a conflict between your legal plan documents and this information, the plan documents will govern.

Excellus BlueCross BlueShield

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A nonprofit independent licensee of the Blue Cross Blue Shield Association

18369-23M