




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 1-888-205-3154 or Syracuse City School District at 1-315-435-4171. 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.excellusbcbs.com](http://www.excellusbcbs.com) or call 1-888-205-3154 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">participating providers</a> : \$0 For <a href="#">non-participating providers</a> : \$75/ individual or \$225/ family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">participating providers</a> : \$7,150/ individual or \$14,300/ family For <a href="#">non-participating providers</a> : \$7,150/ individual or \$14,300/ family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> of not more than \$7,150 until the overall family <a href="#">out-of-pocket limit</a> has been met
What is not included in the <a href="#">out-of-pocket limit</a> ?	Costs for <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">participating provider</a> ?	Yes. See <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a> or call 1-888-205-3154 for a list <a href="#">participating providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use a <a href="#">non-participating provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">participating provider</a> might use an <a href="#">non-participating provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a referral.

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$15 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening</a> /immunization	Adult physical: No charge Adult immunizations: No charge Well child visit: No charge <a href="#">Deductible</a> does not apply	Adult physical: No charge Adult immunizations: No charge Well child visit: No charge <a href="#">Deductible</a> does not apply	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.  Adult physical exam is limited to one (1) exam per calendar year.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Outpatient facility: \$15 <a href="#">copay</a> /visit Professional services: \$15 <a href="#">copay</a> /visit	Outpatient facility: \$15 <a href="#">copay</a> /visit Professional services: 20% <a href="#">coinsurance</a>	There is no charge for routine diagnostic tests that are performed within 30 calendar days of a routine physical exam.
	Imaging (CT/PET scans, MRIs)	\$15 <a href="#">copay</a> /visit	\$15 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.caremark.com</a>	Generic drugs (Tier 1)	\$5 <a href="#">copay</a> per prescription (retail) \$12.50 <a href="#">copay</a> per prescription (mail order)		<a href="#">Out-of-pocket limit</a> applies.
	Preferred brand drugs (Tier 2)	25% <a href="#">coinsurance</a> per prescription (retail) \$75 <a href="#">copay</a> per prescription (mail order)		Certain <a href="#">prescription drugs</a> require <a href="#">preauthorization</a> . If you don't get <a href="#">preauthorization</a> , your <a href="#">prescription drug</a> will not be covered.
	Non-preferred brand drugs (Tier 3)	25% <a href="#">coinsurance</a> per prescription (retail) \$95 <a href="#">copay</a> per prescription (mail order)		
	<a href="#">Specialty drugs</a> (Tier 4)	25% <a href="#">coinsurance</a> per prescription (retail) \$95 <a href="#">copay</a> per prescription (mail order)		Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order).  You must pay the difference in the cost between a generic drug and a brand-name drug, regardless of circumstances, until the <a href="#">out-of-pocket limit</a> is met.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.syracusecityschools.com](http://www.syracusecityschools.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$15 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	There is no charge and the <a href="#">deductible</a> does not apply for services rendered by a <a href="#">participating provider</a> or <a href="#">non-participating provider</a> in an ambulatory surgical center.
	Physician/surgeon fees	\$15 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	Emergency Services (Facility): \$100 <a href="#">copay</a> /visit Non-Emergency Services (Facility): 20% <a href="#">coinsurance</a>	Emergency Services (Facility): \$100 <a href="#">copay</a> /visit Non-Emergency Services (Facility): 20% <a href="#">coinsurance</a>	<b><a href="#">Participating Provider</a> - Professional Services:</b> Emergency Services: No charge Non-Emergency Services: Not covered <b><a href="#">Non-Participating Provider</a> – Professional Services:</b> Emergency Services: No charge; <a href="#">deductible</a> does not apply Non-Emergency Services: Not covered
	<a href="#">Emergency medical transportation</a>	No charge	No charge, <a href="#">deductible</a> does not apply	None
	<a href="#">Urgent care</a>	\$15 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <a href="#">copay</a> /visit	\$100 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	None
	Physician/surgeon fees	No charge	No charge, <a href="#">deductible</a> does not apply	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	None
	Inpatient services	\$100 <a href="#">copay</a> /visit	\$100 <a href="#">copay</a> /visit	
If you are pregnant	Office visits	No charge	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	No charge, <a href="#">deductible</a> does not apply	
	Childbirth/delivery facility services	\$100 <a href="#">copay</a>	\$100 <a href="#">copay</a> , <a href="#">deductible</a> does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	No charge, <a href="#">deductible</a> does not apply	Limited to 40 visits per calendar year.
	<a href="#">Rehabilitation services</a>	\$15 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	\$15 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	\$100 <a href="#">copay</a>	\$100 <a href="#">copay</a> , <a href="#">deductible</a> does not apply	None
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	No charge	No charge, <a href="#">deductible</a> does not apply	None
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>Acupuncture (only covered in lieu of anesthesia)</li> <li>Cosmetic surgery</li> <li>Dental care (Adult &amp; Child)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult &amp; Child)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private duty nursing</li> </ul>	

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://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

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.syracusecityschools.com](http://www.syracusecityschools.com).

provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: [www.excellusbcbs.com](http://www.excellusbcbs.com) or call 1-888-205-3154 or call Syracuse City School District at 1-315-435-4171. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Community Service Society of New York, Community Health Advocates, 633 Third Avenue, 10th floor, New York, NY 10017, (888) 614-5400, <http://www.communityhealthadvocates.org/> (website), [cha@cssny.org](mailto:cha@cssny.org) (email). A list of states with Consumer Assistance Programs is available at: [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-205-3154.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-205-3154.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-205-3154.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-205-3154.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">copayment</a>	\$100
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$460</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">copayment</a>	\$100
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$420</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$15
■ Hospital (facility) <a href="#">copayment</a>	\$100
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$300</b>

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