




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 or call 1-888-205-3154 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For participating providers : \$0 For non-participating providers : \$75/ individual or \$225/ 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 , 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 is covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For participating providers : \$7,150/ individual or \$14,300/ family For non-participating providers : \$7,150/ individual or \$14,300/ 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 limit of not more than \$7,150 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 participating provider ?	Yes. See www.excellusbcbs.com or call 1-888-205-3154 for a list participating 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 a non-participating 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 participating provider might use an non-participating 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay /visit	20% coinsurance	None
	Specialist visit	\$15 copay /visit	20% coinsurance	None
	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 Deductible does not apply	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. Adult physical exam is limited to one (1) exam per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient facility: \$15 copay /visit Professional services: \$15 copay /visit	Outpatient facility: \$15 copay /visit Professional services: 20% coinsurance	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 copay /visit	\$15 copay /visit, deductible does not apply	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs (Tier 1)	\$2 copay per prescription (retail) \$14 copay per prescription (mail order)		Out-of-pocket limit applies.
	Preferred brand drugs (Tier 2)	25% coinsurance per prescription (retail) \$75 copay per prescription (mail order)		Certain prescription drugs require preauthorization . If you don't get preauthorization , your prescription drug will not be covered.
	Non-preferred brand drugs (Tier 3)	25% coinsurance per prescription (retail) \$95 copay per prescription (mail order)		
	Specialty drugs (Tier 4)	25% coinsurance per prescription (retail) \$95 copay 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 out-of-pocket limit is met.

* For more information about limitations and exceptions, see the [plan](#) or policy document at 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 copay /visit	20% coinsurance	There is no charge and the deductible does not apply for services rendered by a participating provider or non-participating provider in an ambulatory surgical center.
	Physician/surgeon fees	\$15 copay /visit	20% coinsurance	
If you need immediate medical attention	Emergency room care	Emergency Services (Facility): \$100 copay /visit Non-Emergency Services (Facility): 20% coinsurance	Emergency Services (Facility): \$100 copay /visit Non-Emergency Services (Facility): 20% coinsurance	Participating Provider - Professional Services: Emergency Services: No charge Non-Emergency Services: Not covered Non-Participating Provider – Professional Services: Emergency Services: No charge; deductible does not apply Non-Emergency Services: Not covered
	Emergency medical transportation	No charge	No charge, deductible does not apply	None
	Urgent care	\$15 copay /visit	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 copay /visit	\$100 copay /visit, deductible does not apply	None
	Physician/surgeon fees	No charge	No charge, deductible does not apply	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay /visit	20% coinsurance	None
	Inpatient services	\$100 copay /visit	\$100 copay /visit	
If you are pregnant	Office visits	No charge	20% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a copayment , coinsurance or deductible 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, deductible does not apply	
	Childbirth/delivery facility services	\$100 copay	\$100 copay , deductible 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)	
If you need help recovering or have other special health needs	Home health care	No charge	No charge, deductible does not apply	Limited to 40 visits per calendar year.
	Rehabilitation services	\$15 copay /visit	20% coinsurance	None
	Habilitation services	\$15 copay /visit	20% coinsurance	
	Skilled nursing care	\$100 copay	\$100 copay , deductible does not apply	None
	Durable medical equipment	No charge	20% coinsurance	None
	Hospice services	No charge	No charge, deductible does not apply	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also

* For more information about limitations and exceptions, see the [plan](#) or policy document at 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 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 (email). A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet the Minimum Value Standards? Yes.

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

Language Access Services:

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

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 plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$100
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$460

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	\$15
■ Hospital (facility) copayment	\$100
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$320

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$100
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$300

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