The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to [www.bcbswny.com](http://www.bcbswny.com) or call 1-888-839-5169. Complete Prescription plan information can be obtained at [www.pbdrx.com](http://www.pbdrx.com) or by calling 1-888-878-9172. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [http://www.dol.gov/ebsha/pdfs/SBCUniformGlossary.pdf](http://www.dol.gov/ebsha/pdfs/SBCUniformGlossary.pdf) or call 1-888-839-5169 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For network providers $0; for</td>
<td>Generally, you must pay all the costs from providers up to the deductible amount</td>
</tr>
<tr>
<td></td>
<td>out-of-network providers $1,000</td>
<td>before this plan begins to pay. If you have other family members on the plan,</td>
</tr>
<tr>
<td></td>
<td>individual /$2,000 family</td>
<td>each family member must meet their own individual deductible until the total amount</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes, network providers services and prescription drugs are not subject to a deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For network providers $5,125 individual / $10,250 family (medical): $1,725/$3,450 (Rx); for out-of-network providers $2,500 individual / $5,000 family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.bcbswny.com">www.bcbswny.com</a> or call 1-888-839-5169 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the in-network specialist you choose without permission from this plan.</td>
</tr>
</tbody>
</table>
**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Group Name:** LMHF POS 204-PBA

**Coverage Beginning on or After:** 1/1/2018

**Coverage for:** All Tiers | Plan Type: POS

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**Common Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information**
--- | --- | --- | ---

**If you visit a health care provider’s office or clinic**

- **Primary care visit to treat an injury or illness**
  - Network Provider: $15 **copayment**
  - Out-of-Network Provider: 25% **coinsurance**

- **Specialist visit**
  - Network Provider: $15 **copayment**
  - Out-of-Network Provider: 25% **coinsurance**

- **Preventive care/screening/immunization**
  - Network Provider: Covered in full
  - Out-of-Network Provider: 25% **coinsurance**

**If you have a test**

- **Diagnostic test** (x-ray, blood work)
  - Network Provider: $0 **copayment** for Lab
  - Out-of-Network Provider: 25% **coinsurance**

- **Imaging** (CT/PET scans, MRIs)
  - Network Provider: $15 **copayment**
  - Out-of-Network Provider: 25% **coinsurance**

**If you need drugs to treat your illness or condition**

- **Generic drugs (Tier 1)**
  - Network Provider: $10 co-pay/prescription (retail and mail order)
  - Out-of-Network Provider: 25% **coinsurance**

- **Preferred brand drugs (Tier 2)**
  - Network Provider: $15 co-pay/prescription (retail and mail order)
  - Out-of-Network Provider: 25% **coinsurance** if no generic is available

- **Non-preferred brand drugs (Tier 3)**
  - Network Provider: $20 co-pay/prescription (retail and mail order); $0 copay/prescription contraceptives if no generic is available
  - Out-of-Network Provider: **Not Applicable**

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*All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.*

More information about **prescription drug coverage** is available at [www.pbdrx.com](http://www.pbdrx.com).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>$10 co-pay/generic $15 co-pay/preferred brand $20 co-pay/non-preferred brand</td>
<td>$15 co-pay/generic $15 co-pay/preferred brand $20 co-pay/non-preferred brand</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$15 copayment</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Covered in full</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100 copayment</td>
<td>$100 copayment</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$100 copayment</td>
<td>$100 copayment</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15 copayment</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250 copayment</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Covered in full</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$15 copayment for Mental Health $15 copayment for Substance Abuse</td>
<td>25% coinsurance for Mental Health 25% coinsurance for Substance Abuse</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$250 copayment for Inpatient Mental Health $250 copayment for Substance Abuse detox $250 copayment for Substance Abuse rehab</td>
<td>25% coinsurance for Mental Health 25% coinsurance for Substance Abuse detox 25% coinsurance for Substance Abuse Rehab</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$15 copayment</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>leads to initial visit to determine pregnancy. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Childbirth/delivery professional services Covered in full</td>
<td>25% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services $250 copayment</td>
<td>25% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Home health care Covered in full</td>
<td>25% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services $15 copayment</td>
<td>25% coinsurance</td>
<td>30 visits per plan yr aggregate IN &amp; OON with PT, ST &amp; OT. Separate benefit for each therapy</td>
</tr>
<tr>
<td></td>
<td>Habilitation services Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care Covered in full</td>
<td>25% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment 50% coinsurance</td>
<td>50% coinsurance</td>
<td>Prior authorization required on certain equipment. Call the number on the back of your ID card for details.</td>
</tr>
<tr>
<td></td>
<td>Hospice services Covered in full</td>
<td>25% coinsurance</td>
<td>210 days maximum</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam $15 copayment</td>
<td>25% coinsurance</td>
<td>Covered in full for 1 routine per year</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses See limitations and exceptions Not covered</td>
<td></td>
<td>Discounts may apply.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

**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.):**

- Dental (Adult)
- Private-duty nursing
- 90-day supply of non-maintenance drugs
- Cosmetic surgery
- Habilitation Services
- Acupuncture
- Custodial Care
- Hearing aids
- 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
- Non-emergency care when traveling outside the U.S.
- Chiropractic Care
- Routine eye care (Adult)
- Infertility treatment
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-888-839-5169.

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

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-249-2583.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-249-2583.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-249-2583.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-249-2583.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Group Name:** LMHF POS 204-PBA

**Coverage Beginning on or After:** 1/1/2018

**Coverage for:** All Tiers | **Plan Type:** POS

---

### 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** $250
- **Other copayment** $15

This EXAMPLE event includes services like:

- Specialist office visits *(prenatal care)*
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests *(ultrasounds and blood work)*
- Specialist visit *(anesthesia)*

**Total Example Cost** $12,800

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$650</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $96

**The total Peg would pay is** $746

---

#### 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** $250
- **Other copayment** $10

This EXAMPLE event includes services like:

- Primary care physician office visits *(including disease education)*
- Diagnostic tests *(blood work)*
- Prescription drugs
- Durable medical equipment *(glucose meter)*

**Total Example Cost** $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$795</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $55

**The total Joe would pay is** $850

---

#### 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** $250
- **Other copayment** $15

This EXAMPLE event includes services like:

- Emergency room care *(including medical supplies)*
- Diagnostic test *(x-ray)*
- Durable medical equipment *(crutches)*
- Rehabilitation services *(physical therapy)*

**Total Example Cost** $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$405</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$18</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $0

**The total Mia would pay is** $423

---

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

BlueCross BlueShield of Western New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BlueCross BlueShield of Western New York does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BlueCross BlueShield of Western New York:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  o Qualified sign language interpreters
  o Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  o Qualified interpreters
  o Information written in other languages

If you need these services, please call the customer service number on the back of your ID card or contact Carleen Dunne, Director, Corporate Compliance & Privacy Officer.

If you believe that BlueCross BlueShield of Western New York has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Carleen Dunne, Director, Corporate Compliance & Privacy Officer, 257 W Genesee St., Buffalo, NY 14202, (716) 887-8624, (716) 887-6056, dunne.carleen@healthnow.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Michele Salerno, Regulatory Compliance Manager is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).


For assistance in English, call the customer service at the number listed on your ID card.
Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.


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

Discrimination is Against the Law

Pharmacy Benefit Dimensions is a subsidiary of Independent Health and complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Pharmacy Benefit Dimensions does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Pharmacy Benefit Dimensions:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
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  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Pharmacy Benefit Dimensions’ Member Services Department.

If you believe that Pharmacy Benefit Dimensions has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Pharmacy Benefit Dimensions’ Member Services Department, 511 Farber Lakes Drive, Buffalo, NY 14221, 1-800-501-3439, TTY users call 1-800-432-1110, fax (716) 655-3504, memberservice@servicing.independenthealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pharmacy Benefit Dimensions’ Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)


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