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 or call 1-888-839-5169. Complete Prescription plan information can be obtained at 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/ebia/pdf/SBCUniformGlossary.pdf or call 1-888-839-5169 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th><strong>What is the overall deductible?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why This Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>For <strong>network providers</strong> $0; for <strong>out-of-network providers</strong> $250 individual / $500 family</td>
<td>Generally, you must pay all of the costs from providers up to the <strong>deductible</strong> amount before this <strong>plan</strong> begins to pay. If you have other family members on the <strong>plan</strong>, each family member must meet their own individual <strong>deductible</strong> until the total amount of <strong>deductible</strong> expenses paid by all family members meets the overall family <strong>deductible</strong>.</td>
<td></td>
</tr>
</tbody>
</table>

| **Are there services covered before you meet your deductible?** | **Yes, **network providers** services and prescription drugs are not subject to a **deductible**. | This **plan** covers some items and services even if you haven’t yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without cost-sharing and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/. |

| **Are there other deductibles for specific services?** | **No** | You don’t have to meet **deductibles** for specific services. |

| **What is the out-of-pocket limit for this **plan**?** | For **network providers** $5,125 individual / $10,250 family (medical): $1,725/$3,450 (Rx); for **out-of-network providers** $2,000 individual / $4,000 family | The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own out-of-pocket limits until the overall family **out-of-pocket limit** has been met. |

| **What is not included in the out-of-pocket limit?** | **Premiums, balance-billing** charges, and health care this **plan** doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**. |

| **Will you pay less if you use a network provider?** | **Yes. See www.bcbswny.com or call 1-888-839-5169 for a list of network providers.** | This **plan** uses a provider **network**. You will pay less if you use a **provider** in the plan’s **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the provider’s charge and what your **plan** pays (balance billing). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services. |

| **Do you need a referral to see a specialist?** | **No.** | You can see the in-network **specialist** you choose without permission from this plan. |
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Beginning on or After: 1/1/2018
Coverage for: All Tiers| Plan Type: POS

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

<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><strong>Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Core: $10 copay Plus: $0 or $5 copay</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Core: $10 copay Plus: $20 or $15 copay</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Covered in full</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$0 copayment for Lab; PCP/Specialist copayment for x-ray</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>PCP/Specialist copayment</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs (Tier 1)</td>
<td>$1 co-pay/prescription (retail and mail order) $0 co-pay/prescription contraceptives</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>$10 co-pay/prescription (retail and mail order) $0 co-pay/prescription contraceptives if no generic is available</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>$25 co-pay/prescription (retail and mail order); $0 copay/prescription contraceptives if no generic is available</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [www.pbdrx.com](http://www.pbdrx.com)
### Summary of Benefits and Coverage

What this Plan Covers & What You Pay For Covered Services

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

**Coverage for:** All Tiers

**Plan Type:** POS

<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></td>
<td>$1 co-pay/generic</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$10 co-pay/preferred brand</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25 co-pay/non-preferred brand</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Core: $10 copay</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plus: $20 or $15 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Covered in full</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$50 copayment</td>
<td>$50 copayment</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>Core: $10 copay</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plus: $0 or $5 copay</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$0 copayment</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Covered in full</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Core: $10 copay
- Plus: $20 or $15 copay
- 20% coinsurance
- None
<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>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$0 copayment for Mental Health</td>
<td>20% coinsurance for Mental Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0 copayment for Substance Abuse</td>
<td>20% coinsurance for Substance Abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0 copayment for Inpatient Mental Health</td>
<td>20% coinsurance for Mental Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0 copayment for Substance Abuse detox</td>
<td>20% coinsurance for Substance Abuse detox</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0 copayment for Substance Abuse rehab</td>
<td>20% coinsurance for Substance Abuse Rehab</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Core: $10 copay</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plus: $0 or $5 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Covered in full</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$0 copayment</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Core: $10 copay</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plus: $20 or $15 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Core: $10 copay</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plus: $20 or $15 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Covered in full</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>Covered in full</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>Core: $10 copay</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plus: $20 or $15 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>See limitations &amp; exceptions</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

- If you are pregnant
- If you need help recovering or have other special health needs
- If your child needs dental or eye care

**Notes:**
- For network providers, copayment applies only to initial visit to determine pregnancy. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
- Prior authorization required on certain equipment. Call the number on the back of your ID card for details.
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
- 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/ebia, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet Minimum Value Standards? Yes.

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

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-249-2583.
[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): Dine'ehgo shika a'tohwol ninisingo, kwiijigoh 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:** Orchard Park POS 203-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** $10
- **Hospital (facility) copayment** $0
- **Other copayment** $10

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost** $12,800

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</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 $296

---

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

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

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost** $7,400

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$620</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 $675

---

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

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

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost** $1,900

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$330</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$18</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $55
- The total Mia would pay is $348

---

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). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Rele nimewo sèvis ki nan kat ID ou pou ouv nan Kreyòl Ayisyen.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

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.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d’identification.

Para sa tulungan sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

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:
  ○ Qualified sign language interpreters
  ○ 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)


English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-665-1502 (TTY: 1-800-432-1110).

Spanish

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-665-1502（TTY ：1-800-432-1110）。

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Звоните 1-800-665-1502 (телефон: 1-800-432-1110).

French

Italian

Yiddish
איפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-665-1502 (TTY: 1-800-432-1110)

Bengali
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Polish

Arabic

French

Urdu
محترم: اگر آپ اردو بولتے ہیں تو آپ کو زبان کی مدد کی خدمات متوسطہ میں دستیاب ہیں۔ برقرار 1-800-665-1502 (TTY: 1-800-432-1110)

Tagalog

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Albanian