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 Excellus BlueCross BlueShield at 1-877-253-4797 or call Cortland County at 1-607-753-5076. 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 1-877-253-4797 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$100 individual/$300 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 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?	$500 individual/$1,500 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
		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	20% coinsurance	None
	Specialist visit	20% coinsurance	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)	No charge, deductible does not apply	No charge, deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	No charge, deductible does not apply	No charge, deductible does not apply	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cap-rx.com	Generic drugs (Tier 1)	$10 copayment /prescription (retail and mail order), deductible does not apply		Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$20 copayment /prescription (retail), deductible does not apply $40 copayment /prescription (mail order), deductible does not apply		
	Non-preferred brand drugs (Tier 3)	$35 copayment /prescription (retail), deductible does not apply $70 copayment /prescription (mail order), deductible does not apply		
	Specialty drugs	Up to $50 copayment per 30 day supply, deductible does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge, deductible does not apply	No charge, deductible does not apply	None
	Physician/surgeon fees	No charge, deductible does not apply	No charge, deductible does not apply	None

* For more information about limitations and exceptions, see the plan or policy document at the Cortland County website: http://www.cortland-co.org/309/Employee-Benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No charge, deductible does not apply	No charge, deductible does not apply	Emergency room care for a non-emergency medical condition is subject to the deductible and 20% coinsurance.
	Emergency medical transportation	No charge, deductible does not apply	No charge, deductible does not apply	None
	Urgent care	No charge, deductible does not apply	No charge, deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge, deductible does not apply	No charge, deductible does not apply	None
	Physician/surgeon fees	No charge, deductible does not apply	No charge, deductible does not apply	Limited to 120 visits per calendar year. All visits after 120 are subject to the deductible and 20% coinsurance.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	None
	Inpatient services	No charge, deductible does not apply	No charge, deductible does not apply	
If you are pregnant	Office visits	No charge, deductible does not apply	No charge, deductible does not apply	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, deductible does not apply	No charge, deductible does not apply	
	Childbirth/delivery facility services	No charge, deductible does not apply	No charge, deductible does not apply	
If you need help recovering or have other special health needs	Home health care	No charge, deductible does not apply	No charge, deductible does not apply	Limited to 40 visits per calendar year.
	Rehabilitation services	20% coinsurance	20% coinsurance	Occupational therapy is not covered, unless part of the home health care benefit above.
	Habilitation services	20% coinsurance	20% coinsurance	Occupational therapy is not covered, unless part of the home health care benefit above.
	Skilled nursing care	No charge, deductible does not apply	No charge, deductible does not apply	None
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice services	20% coinsurance	20% coinsurance	Family bereavement counseling is limited to five (5) visits per calendar year. Inpatient and

* For more information about limitations and exceptions, see the plan or policy document at the Cortland County website: http://www.cortland-co.org/309/Employee-Benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				outpatient benefits are limited to 210 visits per lifetime.
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.)

- Acupuncture (only covered in lieu of anesthesia)
- Cosmetic surgery
- Dental care (Adult & Child)
- Hair prosthetics
- Hearing aids
- Long-term care
- Reproductive services
- 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.)

- Bariatric surgery
- Chiropractic care. Limited to 30 visits per calendar year
- Infertility treatment (inpatient hospital to treat infertility are not covered)
- Non-emergency care when traveling outside the U.S., unless travel is for the sole purpose of obtaining medical services
- Private duty nursing (inpatient is not covered)

* For more information about limitations and exceptions, see the plan or policy document at the Cortland County website: http://www.cortland-co.org/309/Employee-Benefits.

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 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 1-800-499-1275 or call Cortland County at 1-607-753-5076. 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.gove/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 1-800-499-1275.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-499-1275.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-499-1275.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-499-1275.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at the Cortland County website: http://www.cortland-co.org/309/Employee-Benefits.

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	$100
Specialist coinsurance	20%
Hospital (facility) coinsurance	0%
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	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$100
Specialist coinsurance	20%
Hospital (facility) coinsurance	0%
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	$100
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$520**

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

The plan's overall deductible	$100
Specialist coinsurance	20%
Hospital (facility) coinsurance	0%
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	$100
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$00
The total Mia would pay is	**$310**

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

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- 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, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan 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:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator 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)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.