



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.excellusbcbcs.com](http://www.excellusbcbcs.com) or call 1-877-253-4797 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$100 individual/\$300 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> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$500 individual/\$1,500 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 limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.excellusbcbcs.com">www.excellusbcbcs.com</a> or call 1-800-499-1275 for a list of <a href="#">network 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 an <a href="#">out-of-network 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="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	None
	Imaging (CT/PET scans, MRIs)	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cap-rx.com">www.cap-rx.com</a>	Generic drugs (Tier 1)	\$10 <a href="#">copayment</a> /prescription (retail and mail order), <a href="#">deductible</a> 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 <a href="#">copayment</a> /prescription (retail and mail order), <a href="#">deductible</a> does not apply		
	Non-preferred brand drugs (Tier 3)	\$35 <a href="#">copayment</a> /prescription (retail and mail order), <a href="#">deductible</a> does not apply		
	<a href="#">Specialty drugs</a>	Same retail or mail order <a href="#">copayment</a> as the listed above depending on if Tier 1, Tier 2, or Tier 3, <a href="#">deductible</a> does not apply		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	None
	Physician/surgeon fees	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> 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)	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	Emergency room care for a non-emergency medical condition is subject to the <a href="#">deductible</a> and 20% <a href="#">coinsurance</a> .
	<a href="#">Emergency medical transportation</a>	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	None
	<a href="#">Urgent care</a>	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	None
	Physician/surgeon fees	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	Limited to 120 visits per calendar year. All visits after 120 are subject to the <a href="#">deductible</a> and 20% <a href="#">coinsurance</a> .
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Inpatient services	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	
<b>If you are pregnant</b>	Office visits	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	<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, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	
	Childbirth/delivery facility services	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	Limited to 40 visits per calendar year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Occupational therapy is not covered, unless part of the home health care benefit above.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Occupational therapy is not covered, unless part of the home health care benefit above.
	<a href="#">Skilled nursing care</a>	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	None
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	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.
<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:**

<b>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>.)</b>		
<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>• Hair prosthetics</li> <li>• Hearing aids</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Reproductive services</li> <li>• Routine eye care (Adult &amp; Child)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care. Limited to 30 visits per calendar year</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment (inpatient hospital to treat infertility are not covered)</li> <li>• Non-emergency care when traveling outside the U.S., unless travel is for the sole purpose of obtaining medical services</li> </ul>	<ul style="list-style-type: none"> <li>• Private duty nursing (inpatient is not covered)</li> </ul>

\* 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](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 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.excellusbcbcs.com](http://www.excellusbcbcs.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](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 1-800-499-1275.

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, kwijjigo holne' 1-800-499-1275.

*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](#) \$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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$70</b>

### 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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$520</b>

### 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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$00
<b>The total Mia would pay is</b>	<b>\$310</b>

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>.