YOUR BENEFIT PLAN DETAILS

**Group Name**
The U.A. Local 13

**Plan Type**
Signature Hybrid 1
Welcome

With Excellus BlueCross BlueShield, you get what you expect from Blue plus a whole lot more such as:

• More doctors, specialists, and hospitals to choose from
• Exclusive discounts on health-related products and services with Blue365®
• Answers to your health questions online
• Local customer service

In this booklet you will find:

• A chart that summarizes this plan’s unique benefits and coverage*
• A glossary of terms to help you understand your coverage and options

We have many valuable benefits and we provide a tremendous amount of choice. Whichever plan you pick, we’re ready to meet your health care needs.

Visit us at excellusbcbs.com

*This benefit summary is not a contract or binding agreement; it is a summary of benefits and services.

Privacy Policy Notice. We know how important your privacy is and we’re committed to protecting it. Our policies and practices regarding the collection, use, and disclosure of personal health information are available at excellusbcbs.com and Member Services.
The U.A. Local 13

Signature Hybrid 1

<table>
<thead>
<tr>
<th>Plan Features</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>Not Required</td>
</tr>
<tr>
<td>Referrals</td>
<td>Not Required</td>
</tr>
<tr>
<td>Out of network benefits</td>
<td>Covered</td>
</tr>
<tr>
<td>Student / Dependent Coverage</td>
<td>Covered to age 26</td>
</tr>
<tr>
<td>Domestic Partner</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Coverage Period</td>
<td>05/01/20-04/30/21</td>
</tr>
<tr>
<td>Office visit copay (Primary Care Physician)</td>
<td>$40</td>
</tr>
<tr>
<td>Office visit copay (Specialist)</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>In Network: 20% Out of Network: 40%</td>
</tr>
<tr>
<td>Deductible</td>
<td>In-network:$1,500 Single/$4,500 Fam; OON:$3,000 Single/$9,000 Fam</td>
</tr>
<tr>
<td>Out of pocket maximum</td>
<td>In-network:$4,000 Single/$12,000 Fam; OON:$8,000 Single/$24,000 Fam</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>None</td>
</tr>
</tbody>
</table>
**General Information**

### Cost Sharing Expenses

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible - Single</td>
<td>$1,500</td>
<td>$3,000</td>
<td></td>
</tr>
<tr>
<td>Deductible - Family</td>
<td>$4,500</td>
<td>$9,000</td>
<td>Each individual does not exceed the single deductible.</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>20%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Annual Out of Pocket Maximum - Single</td>
<td>$4,000</td>
<td>$8,000</td>
<td>Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.</td>
</tr>
<tr>
<td>Annual Out of Pocket Maximum - Family</td>
<td>$12,000</td>
<td>$24,000</td>
<td>Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.</td>
</tr>
</tbody>
</table>

### Office Visit Cost Shares

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Share - Primary Care</td>
<td>$40 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Cost Share - Specialist</td>
<td>$60 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Cost Share - Sick Kids</td>
<td>$0 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Plan Limits

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan/Calendar Year</td>
<td></td>
<td></td>
<td>Plan Year Benefits</td>
</tr>
<tr>
<td>Diabetic Preauthorization and Step Therapy</td>
<td></td>
<td></td>
<td>Applies</td>
</tr>
</tbody>
</table>

### Who is Covered

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Partner Coverage</td>
<td></td>
<td></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Inpatient Services

Inpatient Facility
### Benefit Name | In Network | Out of Network | Limits and Additional Information
--- | --- | --- | ---
Inpatient Hospital Services | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 
Mental Health Care | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 
Substance Use Detoxification | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 45 Days per plan year Limits are combined INN and OON.
Skilled Nursing Facility | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 60 Days per plan year Limits are combined INN and OON.
Physical Rehabilitation | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 
Maternity Care | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 

### Inpatient Professional Services

### Benefit Name | In Network | Out of Network | Limits and Additional Information
--- | --- | --- | ---
Inpatient Hospital Surgery | PCP/Specialist - 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.
Anesthesia | PCP/Specialist - 20% Coinsurance Subject to Deductible | 20% Coinsurance Subject to $1,500 Deductible | 

### Outpatient Facility Services

### Benefit Name | In Network | Out of Network | Limits and Additional Information
--- | --- | --- | ---
SurgiCenters and Freestanding Ambulatory Centers Surgical Care | 20% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible | 
Diagnostic X-ray | $60 Copayment | 40% Coinsurance Subject to Deductible | 
Diagnostic Laboratory and Pathology | Covered in Full | 40% Coinsurance Subject to Deductible | 
Radiation Therapy | $60 Copayment | 40% Coinsurance Subject to Deductible | 
Chemotherapy | $40 Copayment | 40% Coinsurance Subject to Deductible | 
Infusion Therapy | Inclusive of Primary Service | Inclusive of Primary Service | Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis | Covered in Full | 40% Coinsurance Subject to Deductible | 
Mental Health Care | $40 Copayment $0 PCP Copay for members to age 19. | 40% Coinsurance Subject to Deductible | Includes Partial Hospitalization
Substance Use Care | $40 Copayment $0 PCP Copay for members to age 19. | 40% Coinsurance Subject to Deductible | Includes Partial Hospitalization

### Home and Hospice Care

### Home Care
<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care</td>
<td>Covered in Full</td>
<td>25% Coinsurance Subject to $50 Deductible</td>
<td>Services must be ordered by a Physician/authorized Health Care Professional and provided by an agency or office licensed/certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>Covered in Full</td>
<td>25% Coinsurance Subject to $50 Deductible</td>
<td></td>
</tr>
</tbody>
</table>

**Hospice Care**

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care Inpatient</td>
<td>Covered in Full</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
</tbody>
</table>

**Outpatient and Office Professional Services**

**Professional Services**

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Surgery</td>
<td>PCP - $40 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist - $60 Copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0 PCP Copay for members to age 19.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic X-ray</td>
<td>PCP/Specialist - $60 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Laboratory and Pathology</td>
<td>PCP/Specialist - Covered in Full</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>PCP/Specialist - $60 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>PCP/Specialist - $40 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>PCP/Specialist - Inclusive of Primary Service</td>
<td>Inclusive of Primary Service</td>
<td>Is inclusive in the Home Care benefit and not covered as a separate benefit.</td>
</tr>
<tr>
<td>Dialysis</td>
<td>PCP/Specialist - Covered in Full</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Mental Health Care</td>
<td>PCP - $40 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td>$0 Kids Copay applies to PCP and Specialist</td>
</tr>
<tr>
<td></td>
<td>Specialist - $40 Copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Care</td>
<td>PCP/Specialist - 20% Coinsurance Subject to Deductible</td>
<td>40% Coinsurance Subject to Deductible</td>
<td>Covers online internet consultations between the member and the providers who participate in our telemedicine program for medical conditions that are not an emergency condition.</td>
</tr>
<tr>
<td>TeleMedicine Program</td>
<td>PCP/Specialist - $10 Copayment</td>
<td>Not Covered</td>
<td>Allergy Testing includes injections and scratch and prick tests.</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>PCP/Specialist - $40 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>PCP - $40 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td>Includes desensitization treatments (injections &amp; serums).</td>
</tr>
<tr>
<td></td>
<td>Specialist - $60 Copayment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Treatment Including Serum</td>
<td>PCP/Specialist - Covered in Full</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Hearing Evaluations Routine</td>
<td>PCP/Specialist - $60 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td>1 Exam per plan year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limits are combined INN and OON.</td>
<td></td>
</tr>
</tbody>
</table>

**Rehab and Habilitation**

**Outpatient Facility**
### Benefit Name | In Network | Out of Network | Limits and Additional Information
--- | --- | --- | ---
**Physical Rehabilitation** | $60 Copayment | 40% Coinsurance Subject to Deductible | 45 Visits per plan year. Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

**Occupational Rehabilitation** | $60 Copayment | 40% Coinsurance Subject to Deductible | 45 Visits per plan year. Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

**Speech Rehabilitation** | $60 Copayment | 40% Coinsurance Subject to Deductible | 45 Visits per plan year. Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

### Outpatient Professional Services

| Benefit Name | In Network | Out of Network | Limits and Additional Information
--- | --- | --- | ---
**Physical Rehabilitation** | PCP/Specialist - $60 Copayment | 40% Coinsurance Subject to Deductible | 45 Visits per plan year. Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

**Occupational Rehabilitation** | PCP/Specialist - $60 Copayment | 40% Coinsurance Subject to Deductible | 45 Visits per plan year. Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

**Speech Rehabilitation** | PCP/Specialist - $60 Copayment | 40% Coinsurance Subject to Deductible | 45 Visits per plan year. Includes aggregate of visits for INN and OON and professional and facility covered services for physical, speech, and occupational therapy.

### Preventive Services

#### Preventive Professional Services Meeting Federal Guidelines*

| Benefit Name | In Network | Out of Network | Limits and Additional Information
--- | --- | --- | ---
**Adult Physical Examination** | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | 1 Exam per plan year

**Adult Immunizations** | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible

**Well Child Visits and Immunizations** | PCP/Specialist - Covered in Full | 0% Coinsurance | 40% Coinsurance Subject to Deductible

**Routine GYN Visit** | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible

**Pre/Post-Natal Care** | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible

**Mammography Screening Professional** | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible

**Colonoscopy Screening Professional** | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible

**Bone Density Screening Professional** | PCP/Specialist - Covered in Full | 40% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible

#### Preventive Facility Services Meeting Federal Guidelines*

| Benefit Name | In Network | Out of Network | Limits and Additional Information
--- | --- | --- | ---
**Cervical Cytology Preventative** | Covered in Full | 40% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible

**Mammography Screening Facility** | Covered in Full | 40% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible

**Colonoscopy Screening Facility** | Covered in Full | 40% Coinsurance Subject to Deductible | 40% Coinsurance Subject to Deductible
<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Density Screening Facility</td>
<td>Covered in Full</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
</tbody>
</table>

**Preventive services in addition to those required under Federal Guidelines - Professional**

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate Cancer Screening</td>
<td>PCP/Specialist - Covered in Full</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Mammography Screening Professional</td>
<td>PCP/Specialist - Covered in Full</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy Screening Professional</td>
<td>PCP/Specialist - Covered in Full</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Bone Density Screening Professional</td>
<td>PCP/Specialist - $60 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
</tbody>
</table>

**Preventive services in addition to those required under Federal Guidelines - Facility**

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography Screening Facility</td>
<td>Covered in Full</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy Screening Facility</td>
<td>Covered in Full</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Bone Density Screening Facility</td>
<td>$60 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
</tbody>
</table>

**Other Benefits**

**Additional Benefits**

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of Diabetes Insulin and Supplies</td>
<td>PCP/Specialist - $40 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td>Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.</td>
</tr>
<tr>
<td>Diabetic Equipment</td>
<td>PCP/Specialist - $40 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>PCP/Specialist - 20% Coinsurance Subject to Deductible</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>PCP/Specialist - 20% Coinsurance Subject to Deductible</td>
<td>40% Coinsurance Subject to Deductible</td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>PCP/Specialist - $60 Copayment</td>
<td>40% Coinsurance Subject to Deductible</td>
<td>10 Visits per contract year</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>PCP/Specialist - Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Emergency Services**

**ER Facility**

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Emergency Room Visit</td>
<td>$350 Copayment</td>
<td>$350 Copayment</td>
<td>Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.</td>
</tr>
</tbody>
</table>

**Transportation**
<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prehospital Emergency and Transportation - Ground or Water</td>
<td>$350 Copayment</td>
<td>$350 Copayment</td>
<td></td>
</tr>
</tbody>
</table>

**Urgent Care**

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Center Facility Visit</td>
<td>$60 Copayment</td>
<td>40% Coinsurance</td>
<td>Subject to Deductible</td>
</tr>
</tbody>
</table>

**Ancillary Benefits**

**Vision**

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Eye Exams - Routine</td>
<td>$60 Copayment</td>
<td>40% Coinsurance</td>
<td>Subject to Deductible 1 Exam per contract year</td>
</tr>
<tr>
<td>Adult Eyewear - Routine</td>
<td>Covered</td>
<td>Covered</td>
<td>$60 Reimbursement Every 2 plan years</td>
</tr>
<tr>
<td>Pediatric Eye Exams - Routine</td>
<td>$60 Copayment</td>
<td>40% Coinsurance</td>
<td>Subject to Deductible 1 Exam per contract year</td>
</tr>
<tr>
<td>Pediatric Eyewear - Routine</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>Subject to Deductible 1 Pair Every 2 plan years</td>
</tr>
</tbody>
</table>

**Rx Benefits**

**Rx Plan**

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rx Plan</td>
<td></td>
<td></td>
<td>$10/$50/$100, $0 Gen for Kids</td>
</tr>
</tbody>
</table>

**Rx Benefits**

<table>
<thead>
<tr>
<th>Benefit Name</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Limits and Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days Supply Per Retail Order</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days Supply Per Mail Order</td>
<td>90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copays Per Mail Order Supply</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits.

* For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.
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Get started today at
www.Blue365Deals.com/register
Healthcare Coverage Wherever You Go

As a Blue™ member, you have more freedom to choose the doctors and hospitals that best suit you and your family. Your membership gives you a world of choices. Within the United States, you're covered whether you need care in urban or rural areas. Outside of the United States, you have access to doctors and hospitals in more than 200 countries and territories around the world through the BlueCard Worldwide® Program.

With the BlueCard Program, you can locate doctors and hospitals quickly and easily. With your Blue Plan ID card handy, follow these steps:

- Visit the Blue National Doctor & Hospital Finder at www.BCBS.com to locate doctors and hospitals, along with maps and directions to find them.
- Blue Cross and Blue Shield Association launched a Blue National Doctor and Hospital Finder app for iPhone, iPad and iPod Touch, allowing you to quickly search for healthcare providers nationwide. There is no charge to download the app from the App Store, but rates from your wireless provider may apply.
- BlueCard Access at 1.800.810.BLUE (2583) for the names and addresses of doctors and hospitals in the area where you or a covered dependent need care.

If you’re a PPO member, always use a BlueCard PPO doctor or hospital to ensure you receive the highest level of benefits.

4. When you arrive at the participating doctor’s office or hospital, show the provider your ID card. The provider will identify your benefit level through one of these symbols:

| Traditional/Indemnity Benefits | PPO Benefits |

Designed to save you money.

In most cases, when you travel or live outside your Blue Plan’s service area, you can take advantage of savings the local Blue Plan has negotiated with its doctors and hospitals. For covered services, you should not have to pay any amount above these negotiated rates and any applicable out-of-pocket expenses.

Take charge of your health, wherever you are.

Within the United States

1. Always carry your current Blue ID card.
2. To find nearby doctors and hospitals, call BlueCard Access at 1.800.810.BLUE (2583) or visit the Blue National Doctor & Hospital Finder at www.BCBS.com.
3. Call your Blue Plan for precertification or prior authorization, if necessary. Refer to the phone number located on your Blue ID card. Note: This phone number is different from the BlueCard Access number mentioned above.

After you receive care, you should:

- Not have to complete any claim forms.
- Not have to pay upfront for medical services, except for the usual out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance).
- Receive an explanation of benefits from your Blue Plan.

In an emergency, go directly to the nearest hospital.
Around the world

1. Verify your international benefits with your Blue Plan before leaving the United States as coverage may be different outside the country.

2. Always carry your current Blue ID card.

3. If you need to locate a doctor or hospital, or need medical assistance services, call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

4. Please see below for the steps that should be taken for inpatient and professional services.

   **Inpatient claim:** Call the BlueCard Worldwide Service Center at 1.800.810.2583 or collect at 1.804.673.1177 when you need inpatient care. In most cases, you should not need to pay upfront for inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket expenses (non covered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit the claim on your behalf. In addition to contacting the BlueCard Worldwide Service Center, call your Blue Plan for precertification or preauthorization. Refer to the phone number on your Blue ID card. Note: this number is different from the phone number listed above.

   **Professional claim:** You pay upfront for care received from a doctor and/or non-participating hospital. Complete a BlueCard Worldwide International claim form and send it with the bill(s) to the BlueCard Worldwide Service Center (the address is on the form). The claim form is available from your Blue Plan, the BlueCard Worldwide Service Center, or online at BCBS.com/bluecardworldwide.
Find a Doctor or Specialist

Excellus BlueCross BlueShield is part of a network of BlueCross BlueShield Plans that make up the largest group of Participation Doctors and Specialists in the world. With that you get cost effective quality health care whenever you need it.

Our online provider directory makes it easy to search for providers by:

- Name
- Zip code
- Gender
- Languages spoken
- Accepting new patients
- Hospital affiliation

Results include:

- Office hours
- Locations
- Phone numbers
- Map & Directions
- Handicap Accessibility

Just look over our alphabetical listing online at ExcellusBCBS.com/FindProvider

ExcellusBCBS.com/FindProvider
3-tier prescription drug benefit

Your three-tier prescription drug benefit makes it easy for you to make informed choices and encourages savings when choosing your medications. Your co-payment will vary based on the tier placement of your prescription drug.

- **Tier One drugs** are typically, generic drugs. Generic drugs have the same active ingredients, strength and effectiveness as their brand-name counterparts but at a substantially lower cost. There may be instances where brand-name drugs may be placed in Tier One for clinical reasons.

- **Tier Two drugs** are typically, brand-name products selected because of their overall value. There may be instances where generic drugs may be placed in Tier Two for clinical reasons.

- **Tier Three drugs** are all other brand name drugs, including new brand name drugs and drugs that have generic equivalents. Visit ExcellusBCBS.com to view our current Tier Three Formulary Guide.

**Where Can I Purchase My Prescription Medications?**
You have access to more than 65,000 participating pharmacies in our nationwide Pharmacy Network, including all national chains and most independent chains. Just show your ID card at any participating pharmacy—it identifies you as having prescription drug coverage and eligible for online claims processing. The pharmacy will transmit your prescription claim online to us and we’ll immediately send a message to the pharmacist with your co-payment amount.

**Home Delivery Service**
Get your prescriptions delivered right to your door! When you use our mail service pharmacy, Express Script® or Wegmans Home Delivery Service, you get the convenience of home delivery, up to a three month’s supply of medication and the ease of ordering new prescriptions and refills either by phone or via our website.

Using mail service pharmacy is ideal for those who take prescription medication on a continuing basis. For more information on how to use Express Script® or Wegmans Home Delivery Service, please visit our website or contact the Pharmacy Help Desk.

**Specialty Pharmacy Benefit**
Specialty medications are designed for conditions that are difficult to treat with traditional medications like multiple sclerosis, rheumatoid arthritis, hepatitis C, and others. These medications are self-administered, either taken orally or by injection. Specialty pharmacies work exclusively with specialty medications and are experts in handling and administering these complex medications.

Your prescription drug benefit provides coverage for certain specialty medications only when purchased at pharmacies participating in the Specialty Pharmacy Network. If you don’t use a participating specialty pharmacy for your new and refill prescriptions, you will be responsible for the full cost of the prescription.

A complete listing of participating specialty pharmacies is available at ExcellusBCBS.com.
Prior Authorization

Prior authorization helps assure that a prescribed drug is safe and appropriate for your medical condition.

Certain medications require prior authorization, which means that your doctor will contact us to get approval before the medication is covered.

Our clinical pharmacists and physicians review medication requests to make sure that the choice of drug or dose is appropriately prescribed based on FDA and manufacturer guidelines, medical literature, safety, appropriate use and benefit design.

Step Therapy

Step Therapy is a program where you must first try a certain drug to treat your condition before another drug will be covered. Your medication treatment moves along a series of “steps.” Generic drugs are usually the first step. This first step lets you begin treatment with a prescription drug that is proven safe and cost effective. If the first step drug does not work for you then move to the next “step.” Brand-name drugs are usually in the second step and have a higher co-payment.

The goal of step therapy is to minimize risk and control costs.

Generic Advantage Program (GAP)

The Generic Advantage Program promotes the use of generic medications. Under this program, if a member chooses a brand-name medication when a generic equivalent is available, the member will pay the generic co-payment or coinsurance amount, plus the difference between the brand-name cost and the generic cost.

For more information about the above programs or to get a specific list of drugs or pharmacies for any of the programs:

- Visit the prescription drug section of our website at ExcellusBCBS.com
- Dial the prescription drug number located on the back of your member ID card.
- Dial the Excellus BlueCross BlueShield Pharmacy Help Desk toll free at 1-800-724-5033 or (TTY) 585-454-2845.
Prevention is the best medicine

Preventive health can help you and your family stay healthy and prevent disease. Preventive care includes immunizations, also known as vaccines. They are safe and effective.

The following vaccines are especially important to consider. The information is based on recommendations from the Centers for Disease Control and Prevention. For more information and a complete listing of recommended vaccines visit the CDC website at cdc.gov/vaccines.

**Tdap:**
This vaccine protects against tetanus, diphtheria and pertussis (whooping cough). Immunity to whooping cough wears off over time, so one dose of Tdap to replace one TD booster is recommended for those ages 11 and older, including adults age 65 and older.

In response to a recent spike in the number of Pertussis cases, the CDC and the American Academy of Pediatrics recommend that women get a booster dose of Tdap vaccine during each pregnancy, ideally between 27 and 36 weeks, regardless of previous Tdap history. If not administered during pregnancy, Tdap should be administered immediately postpartum.

**Varicella (chicken pox), MMR (measles, mumps and rubella), Hepatitis A and Hepatitis B vaccines:**
These vaccines are needed for adults who did not have these diseases or vaccines when they were children. Talk to your health care provider to determine if you need updates.

**HPV:**
HPV (human papillomavirus) vaccine is important because it can help prevent cases of cervical cancer in females if given before exposure to the virus. It may be given to males and females. It is recommended to be given starting at approximately age 11 years, and can be administered up to age 26 years. Talk to your child's doctor about your child having the HPV vaccine.

**Meningococcal:**
Meningococcal disease is a serious bacterial illness. Meningitis is an infection of the covering of the brain and the spinal cord. Adolescents and those with certain health conditions should be routinely immunized with the meningitis vaccine. Speak with your health care provider to learn more about this important vaccine.

**Flu:**
Flu vaccine is recommended for everyone older than 6 months. The best results for children ages 6 months through 8 years are two doses given four weeks apart if receiving the flu vaccine for the first time.

**Pneumonia:**
Infants, very young children and older persons are at highest risk for complications from pneumonia. It is recommended that those with chronic health conditions receive a pneumonia vaccine. Talk to your doctor about the benefit of a pneumonia vaccine.

Visit ExcellusBCBS.com/StayHealthy for more information on immunizations, age-appropriate health screenings and more.
When you’re feeling achy, stuffy, and feverish, the last thing you want to do is drive to your doctor and sit in a waiting room. Telemedicine gives you fast access to medical and behavioral health care 24/7/365, from the comfort of your home, desk, or hotel room. **All you need to do is activate it through your online member account and download the MDLIVE app.**

Rest assured, our health care professionals deliver the same quality of care you receive from your own doctor, but more conveniently via your phone, tablet, or computer. There’s even a chance you’ll see your own doctor on the MDLIVE roster.

**When do you use telemedicine?**
- Instead of going to urgent care or the emergency room for minor and non-life-threatening conditions
- Whenever your primary care doctor is not available
- If you live in a rural area and don’t have access to nearby care
- When you’re traveling for work or on vacation

**Here are some of the common medical conditions treated with telemedicine:**

**Adults**
- Allergies
- Cold and Flu
- Ear Infections
- Fever
- Headache
- Joint Aches and Pains

**Children**
- Cold and Flu
- Constipation
- Earache*
- Fever*
- Nausea and Vomiting
- Pink Eye

*MDLIVE does not provide support for urinary tract infections in males; does not provide support for earache conditions for children under 12 years old; does not provide support for fever-related conditions for children under 3 years old.

Excellus BlueCross BlueShield is a nonprofit independent licensee of the Blue Cross Blue Shield Association.
Telemedicine is good for the mind as well as the body.

In addition to whenever, wherever access to medical doctors, you can also video conference with a psychiatrist or choose from a variety of licensed therapists from the privacy of your own home. You can even schedule recurring appointments to establish an ongoing relationship with one therapist.

If you think behavioral health counseling might be right for you, take one of our free online assessments at [MDLIVE.com/BH-Assessments](http://MDLIVE.com/BH-Assessments). Here are some conditions people rely on behavioral health telemedicine for:

- Addiction
- Bipolar Disorders
- Depression
- Eating Disorders
- Grief and Loss
- LGBTQ Support
- Panic Disorders
- Stress
- Trauma and PTSD

### Telemedicine is covered just like a trip to the doctor.

<table>
<thead>
<tr>
<th>If your doctor’s office visit is...</th>
<th>Then your medical and behavioral health telemedicine program benefit cost share is...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered with a copay</td>
<td>$10 (or equal to the PCP copay if PCP copay is less than $10)</td>
</tr>
<tr>
<td>Covered with copay/deductible</td>
<td>$10 copay subject to deductible (or equal to the PCP copay if PCP copay is less than $10)</td>
</tr>
<tr>
<td>Covered deductible/covered in full</td>
<td>Deductible/covered in full</td>
</tr>
<tr>
<td>Covered with deductible/coinsurance</td>
<td>Deductible/coinsurance</td>
</tr>
<tr>
<td>Covered with coinsurance only</td>
<td>Coinsurance only</td>
</tr>
</tbody>
</table>

**DID YOU KNOW?**

- **70%** of doctor’s office visits could be handled over the phone.1
- **20.3** days is the average wait time between scheduling an appointment and seeing a primary care doctor.2
- **90%** of emergency room visits can potentially be prevented with telemedicine.3

Don’t wait until you need it. There are four easy ways to activate telemedicine today.

**WEB** - Register/Log in at ExcellusBCBS.com/Member  
**APP** - Download the MDLIVE app  
**TEXT** - Text EXCELLUS to 635483  
**VOICE** - Call 1-866-692-5045

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2. Based on MDLIVE data, 2016.
**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Excellus BCBS: Excellus BluePPO Signature Hybrid 1**
A nonprofit independent licensee of the BlueCross BlueShield Association

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 1-800-499-1275 or visit Our website at www.excellusbcbs.com. 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.cciio.cms.gov or www.healthcare.gov/sbc-glossary or call 1-800-499-1275 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>In-Network: $1,500 Individual/$3,000 Two Person/$4,500 Family; Out-of-Network: $3,000 Individual/$6,000 Two Person/$9,000 Family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes, Preventive Care</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>In-Network: $4,000 Individual/$8,000 Two Person/$12,000 Family; Out-of-Network: $8,000 Individual/$16,000 Two Person/$24,000 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>Costs for 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.excellusbcbs.com">www.excellusbcbs.com</a> or call 1-800-499-1275 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 specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

1 of 6
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><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$40 Copay/visit</td>
<td>No Charge for Members to age 19</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$60 Copay/visit</td>
<td>Deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Adult Physical: No Charge</td>
<td>Adult Immunizations: No Charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adult Immunizations: No Charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Well Child Visit: No Charge</td>
<td>Well Child Visit: No Charge</td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>X-Ray: $60 Copay/visit</td>
<td>X-Ray: Deductible does not apply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X-Ray: Deducible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Blood Work: No Charge</td>
<td>Blood Work: Deducible does not apply</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$60 Copay/visit</td>
<td>Deducible does not apply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deducible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you have a test</td>
<td></td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$60 Copay/visit</td>
<td>Deducible does not apply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deducible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you need drugs to treat your illness or condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Generic drugs</td>
<td>$10/prescription retail, $20/prescription mail order</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No Charge Members to age 19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brand drugs</td>
<td>$50/prescription retail, $100/prescription mail order</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deducible does not apply</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see [plan](#) or policy document at www.excellusbcbs.com
<table>
<thead>
<tr>
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<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><strong>In-Network Provider</strong>&lt;br&gt;(You will pay the least)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>$100/prescription retail&lt;br&gt;Deductible does not apply</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room care</td>
<td>$350 Copay/visit&lt;br&gt;Deductible does not apply</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>$350 Copay/visit&lt;br&gt;Deductible does not apply</td>
<td>Not Covered</td>
<td>None</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$60 Copay/visit&lt;br&gt;Deductible does not apply</td>
<td>40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>$40 Copay/visit&lt;br&gt;Deductible does not apply</td>
<td>40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
<td>Cost sharing does not apply for preventive services.</td>
</tr>
<tr>
<td>Office visits</td>
<td>No Charge</td>
<td>40% Coinsurance</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, a copayment, coinsurance, or deductible may apply.</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>No Charge&lt;br&gt;Deductible does not apply</td>
<td>25% Coinsurance</td>
<td>Deductible is limited to $50 Out-of-Network</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$60 Copay/visit&lt;br&gt;Deductible does not apply</td>
<td>40% Coinsurance</td>
<td>45 Visits per plan year limit</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habilitation services</td>
<td>$60 Copay/visit Deductible does not apply</td>
<td>40% Coinsurance</td>
<td>45 Visits per plan year limit</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>45 Days per plan year limit</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>No Charge Deductible does not apply</td>
<td>40% Coinsurance</td>
<td>Family bereavement counseling limited to 5 Visits per plan year</td>
<td></td>
</tr>
</tbody>
</table>

| If your child needs dental or eye care |  |
| Children’s eye exam | $60 Copay/visit Deductible does not apply | 40% Coinsurance | 1 Exam per contract year |
| Children’s glasses | 20% Coinsurance | 40% Coinsurance | 1 Pair Every 2 plan years |
| 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.):**

- Cosmetic surgery
- Long-term care
- Weight loss programs
- Dental care (Adult)
- Private-duty nursing
- Routine foot care
- Dental care (Child)

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):**

- Acupuncture
- Hearing aids
- Routine eye care (Adult)
- Bariatric surgery
- Infertility treatment
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

**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: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: the phone number on Your ID card or www.excellusbcbs.com; Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov.

* For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com
Additionally, a consumer assistance program can help you file your appeal. Contact the Consumer Assistance Program at 1-888-614-5400, or e-mail cha@cssny.org or www.communityhealthadvocates.org. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

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 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.

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network prenatal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td>Deductibles $1,500 Copayments $60 Coinsurance $2,010 What isn’t covered Limits or exclusions $60 <strong>The total Peg would pay is</strong> $3,630</td>
<td>Deductibles $1,500 Copayments $60 Coinsurance $2,010 What isn’t covered Limits or exclusions $60 <strong>The total Joe would pay is</strong> $2,170</td>
<td>Deductibles $1,500 Copayments $60 Coinsurance $2,010 What isn’t covered Limits or exclusions $60 <strong>The total Mia would pay is</strong> $1,170</td>
</tr>
</tbody>
</table>

In this example, Peg would pay:

- Deductibles $1,500
- Copayments $60
- Coinsurance $2,010

What isn’t covered:

- Limits or exclusions $60

The total Peg would pay is $3,630

In this example, Joe would pay:

- Deductibles $0
- Copayments $2,110
- Coinsurance $0

What isn’t covered:

- Limits or exclusions $60

The total Joe would pay is $2,170

In this example, Mia would pay:

- Deductibles $0
- Copayments $970
- Coinsurance $0

What isn’t covered:

- Limits or exclusions $0

The total Mia would pay is $1,170

The plan would be responsible for the other costs of these EXAMPLE covered services.
1-800-368-1099, 800-537-7697 (TDD)
Washington, D.C. 20210
Room 266F, HHH Building
200 Independence Avenue, SW
U.S. Department of Health and Human Services

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:

Fax: 315-671-6556
TTY number: 1-800-421-1220
Telephone number: 1-800-649-5245
Syracuse, NY 13214
P.O. Box 417
Attention: Civil Rights Coordinator
Advocacy Department

If you believe that the Health Plan has failed to provide those services or discriminates in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail or fax. If you need help filling a grievance, the Health Plan’s Civil Rights Coordinator is available to help you.

Fax: 315-671-6556
TTY number: 1-800-421-1220
Telephone number: 1-800-649-5245
Syracuse, NY 13214
P.O. Box 417
Attention: Civil Rights Coordinator
Advocacy Department

Grievance with:

If you need these services, please refer to the enclosed document for ways to reach us.

Information written in other languages
Qualified interpreters

if: Provides free language services to people whose primary language is not English, such as:

Forms, other formats
Written information in other formats (large print, audio, accessible electronic)
Qualified sign language interpreters

Provides free aids and services to people with disabilities to communicate effectively

The Health Plan:

treat them differently because of race, color, national origin, age, disability, or sex.

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.

Notice of Nondiscrimination
Consultez ci-dessous pour savoir comment nous joindre.

Remarque : Si vous parlez français, une assistance linguistique gratuite vous est proposée.

Veuillez noter que ce document contient des informations juridiques et des points de discussions juridiques.

Attention : Se la voie linguistique franco-française dépend de la situation et de l'opération.

B-2456


Tips for reviewers: consent form, medical history, discharge summary, final document.

Proprietary: Avant de commencer le traitement, veuillez lire attentivement le manuel d'utilisation et le livret de consigne.

©2002

Manayunk sumanbaru na nakalika na dokumento para sa mga magar ng pakikipag-uugnayan

Manayunk: Kings ngapiselika ka ng Tagalog, may meas na kaniw na kaping na siling Cran.

Consultez ci-dessous pour savoir comment nous joindre.

Remarque : Si vous parlez français, une assistance linguistique gratuite vous est proposée.

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Tips for reviewers: consent form, medical history, discharge summary, final document.

Proprietary: Avant de commencer le traitement, veuillez lire attentivement le manuel d'utilisation et le livret de consigne.
Commercial Group Health Insurance Application/Change Form

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 4.

Section 1: Employer Group & Benefit Information
To be completed with your Group Administrator

<table>
<thead>
<tr>
<th>Employer Name</th>
<th>Group Administrator’s Signature (required)</th>
<th>Date</th>
<th>Employee Number</th>
<th>Department Number</th>
</tr>
</thead>
</table>

Medical Information
- Medical Group Number (8 digits)
- Medical Subgroup Number (4 digits)
- Medical Class Number (4 digits)

Medical Plan Selection
- Signature Series Hybrid 1 Opt 1 (DAB)

Medical Effective Date: / / 

Subscriber Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Title (e.g., Jr, Sr, III, etc.)</th>
<th>Birthdate: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Gender:
- Male
- Female

Social Security Number**:______________________________

Date of Hire/Rehire: / / 

Retire Date: / / 

Marital Status:
- Single
- Married
- Legally Separated
- Divorced

Marital Status Event Date: / / 

Subscriber’s Medicare Number (if applicable):

<table>
<thead>
<tr>
<th>Part A Effective Date</th>
<th>Part B Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dental Information

Dental Group Number: ____________________

Dental Subgroup Number: ____________________

Dental Class or Package #: / / 

Dental Effective Date:

Dental Plan Selection

Dental Effective Date:

Dental Plan Selection

For Internal Use Only

HIOS ID# ____________________

EC _______________________

Subscriber's Medicare Number (if applicable):

<table>
<thead>
<tr>
<th>Part A Effective Date</th>
<th>Part B Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Confidential

App-352 (0618) [E Signature Series]
Section 3: Reason for enrollment or change - To be completed by the Group Administrator - Not required for cancelations

Enrollment Opportunity: □New Hire □Rehire □Open Enrollment □Medicare eligible

Special Enrollment Opportunity:
□Newly Eligible Dependent □Newborn □Marriage □Other ______
□Change in employment status □Loss of Student Status □Death of Spouse
□Involuntary loss of coverage □Former dependent regains eligibility

Date of Event ___ /___ /____

COBRA Election - Please indicate the reason for COBRA if applicable:
□Left Employment/Retired □Divorce/Legal Separation □Death of Spouse
□Disability □Dependent Reached Max Age □Other: __________________________

Demographic Change: □Address □Birthdate □Subscriber Name □Dependent Name □Phone Number

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

Subscriber
Cancel Codes:
SB02-Left Employment SB05-Per Group Request SB06-Subscriber Request (voluntary) SB07-Deceased SB09-Enrolled in Error

Dependent(s)
Cancel Codes:
M001-Per Group Request M004-Enrolled in Error M008-Moved Out of Area M013-Ineligible
M002-Deceased M005-Divorced M010-Overage Dependent M014-YAO Ineligible
M003-Per Subscriber Request M007-Per Member Request (voluntary) M011-No Longer a Student M040-Mx Same Group

Section 5: Information about who you would like coverage for (dependent information)

□Spouse □Domestic Partner □Dependent Child □Disabled Dependent Child (Separate application form required) □Other ________________

Last Name (if different) Title First Name MI Social Security Number **

Gender: □Male □Female Birthdate ______ / ______ / ________

Is dependent a full time student over age 19? □Yes □No
If yes, please provide name of college/university ____________________________ Expected Graduation Date: ___ /___ /____

Medicare Eligible □Yes □No If yes, indicate reason □Age 65+ □Disability □End Stage Renal *
Part A Effective Date: ___ /___ /____ Part B Effective Date: ___ /___ /____

Medicare Number (if applicable)

Additional Dependent(s)

□Dependent Child □Disabled Dependent Child (Separate application form required) □Other ________________

Last Name (if different) Title First Name MI Social Security Number **

Gender: □Male □Female Birthdate ______ / ______ / ________

Is dependent a full time student over age 19? □Yes □No
If yes, please provide name of college/university ____________________________ Expected Graduation Date: ___ /___ /____

Medicare Eligible □Yes □No If yes, indicate reason □Age 65+ □Disability □End Stage Renal *
Part A Effective Date: ___ /___ /____ Part B Effective Date: ___ /___ /____

Medicare Number (if applicable)
Section 6: Other coverage information (Required) - You may be contacted for additional information

Have you or any member of your family been enrolled in other medical or dental coverage?  □ Yes  □ No
If yes, what type of coverage?  □ Medical  □ Dental
What is the effective date of the other coverage?  □ Medical: ___ / ___ / ______  □ Dental: ___ / ___ / ______
What is the name of the other carrier? _______________________________
Are you keeping the coverage?  □ Yes  □ No
If no, when will the coverage end?  ___ / ___ / ______
Policyholder’s name _______________________________ ID# __________________________

Section 7: Release - You must sign and date this form to be eligible for health insurance

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).
I hereby accept responsibility for payment of any portion of the premium.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

PREFERRED PROVIDER ORGANIZATION (PPO)

I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.

I have thoroughly read, understand and agree to comply with the terms of the release in this section.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber Signature __________________________________________ Date ______________

Note: Use an additional application if more than three dependents need coverage.
### Instructions for completing the Group Health Insurance Application

#### Section 1: Employer Group & Benefit Information
This section should be completed with your Group Administrator. Group Administrator’s signature is required. Medical and/or dental group numbers and information must be populated. Select who you need coverage for on the medical and/or dental plan(s) and indicate the subscriber’s status. Next, select the medical and/or dental plan(s) you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator.

#### Section 2: Subscriber’s Information
This section should be completed by the Subscriber.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.**

* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

#### Section 3: Reason for enrollment or change
Select the box(es) that describe(s) the reason for this enrollment or change regarding health insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group’s anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. You may be required to provide documentation of certain events.

#### Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?
If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

#### Section 5: Information about who you would like coverage for (dependent information)
Please include information about all the people who you would like coverage for.
Use an additional application if more than three dependents need coverage.
If your dependents are Medicare eligible, complete the questions regarding Medicare coverage.
Qualified guidelines for coverage include:
- A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk)
- Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren)
- Child(ren) Only coverage is available for children up to age 26 or 29 depending on the employer group coverage.
- There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a disabled dependent who is over the maximum dependent age. Please contact your Group Administrator for the appropriate form.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.**

* There is additional information needed if eligible for Medicare due to ESRD. Please contact your Group Administrator for the appropriate form.

#### Section 6: Other coverage information (Required)
Please include accurate information in this section. This could affect the processing of your application and/or claims.

#### Section 7: Release
Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.
Health plan terms

To help you better understand our plans and your coverage, here are a few definitions* for frequently used health care terms.

**Primary Care Physician (PCP)**—A doctor who serves as your health care manager and coordinates virtually all of the health care services you routinely receive. Some plans do not require you to choose a PCP.

**Referral**—Instructions provided by a PCP for specialty care. Most plans do not require referrals.

**In-network coverage**—The coverage available when you receive services from a provider who participates in your health plan.

**Out-of-network coverage**—The coverage available when you receive services from a provider who does not participate in your health plan. Some plans may not include out-of-network coverage.

**Out-of-area**—Describes when you receive services while outside the geographic service area of your health plan. Your plan benefits may differ if you live or work beyond the geographic service area.

**Copay**—A dollar amount due at the time you receive certain services. A typical example would be an office visit copay due when visiting your physician’s office for treatment.

**Allowed Amount**—The maximum amount your health plan will pay for a specific service. In-network providers agree to accept the allowed amount as payment in full.

**Coinsurance**—A cost-sharing method that requires you pay a portion of the allowed amount for certain medical services.

**Deductible**—A set dollar amount you pay for covered services you receive before your insurer will make a payment.

**Out-of-pocket maximum**—The maximum amount of deductible and coinsurance payments that you will pay for health services each calendar year.

*Some definitions may vary slightly by plan. In case of a conflict between your legal plan documents and this information, the plan documents will govern.*