Excellus BCBS: Excellus BluePPO

A nonprofit independent licensee of the BlueCross BlueShield Association

Oneida Nation Enterprises One Choice
Coverage Period: 01/01/2019-12/31/2019
Coverage for: Family | **Plan Type:** PPO

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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $500 Individual/$1,000 Two Person/$1,500 Family; Out-of-Network: $1,000 Individual/$2,000 Two Person/ $3,000 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	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?	In-Network: $1,000 Individual/$2,000 Two Person/$3,000 Family; Out-of-Network: $2,500 Individual/$5,000 Two Person/ $7,500 Family. Rx - See page 2.	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. Separate out-of-pocket limit applies to Rx expenses. See page 2.
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
		In-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	$25 Copay/visit Deductible does not apply	40% Coinsurance	$20 Copay for Children under 19 years of age
	Specialist visit	$25 Copay/visit Deductible does not apply	40% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: 40% Coinsurance Adult Immunizations: 40% Coinsurance 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. 1 Exam per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	15% Coinsurance	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% Coinsurance	40% Coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Tier 1 (Generic drugs)	$10 Copay 30-day supply	Same as In-Network	60-day supply: $15 Tier 1 / $50 Tier 2/ $80 Tier 3 90-day supply:$15 Tier 1/ $62.50 Tier 2/ $100 Tier 3 Specialty Medications 20% coinsurance until max is met Retail prescriptions limited to two 30 day supplies before a penalty of $25 is charged for maintenance. Out-of-pocket max: $1000/$2000/$3000 *(Rx only)*
	Tier 2 (Preferred brand drugs)	$25 Copay 30-day supply	Same as In-Network	
	Tier 3 (Non-preferred brand drugs)	$40 Copay 30-day supply	Same as In-Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 Copay then 15% coins Deductible does not apply	40% Coinsurance	None
	Physician/surgeon fees	15% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room care	$250 Copay/visit Deductible does not apply	$250 Copay/visit Deductible does not apply	Copay waived if admitted
	Emergency medical transportation	$100 Copay/visit Deductible does not apply	$100 Copay/visit Deductible does not apply	
	Urgent care	$25 Copay/visit Deductible does not apply	40% Coinsurance	$20 Copay for Children under 19 years of age

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copay then 15% coins Deductible does not apply	40% Coinsurance	None
	Physician/surgeon fees	15% Coinsurance	40% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay/visit Deductible does not apply	40% Coinsurance	Out-patient only: $20 copay per visit for children under 19
	Inpatient services	$100 Copay then 15% coins Deductible does not apply	40% Coinsurance	
If you are pregnant	Office visits	No Charge Deductible does not apply	40% Coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge Deductible does not apply	40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, copayment, coinsurance or deductible may apply.
	Childbirth/delivery facility services	$100 Copay then 15% coins Deductible does not apply	40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	15% Coinsurance	40% Coinsurance	
	Rehabilitation services	$100 copay then 15% Coinsurance	40% Coinsurance	100 days inpatient limit
	Habilitation services	15% Coinsurance	40% Coinsurance	None
	Skilled nursing care	$100 Copay then 15% coins Deductible does not apply	40% Coinsurance	100 Days per contract year limit
	Durable medical equipment	15% Coinsurance	40% Coinsurance	None
	Hospice services	15% Coinsurance	40% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	No Charge Deductible does not apply	No Charge Deductible does not apply	1 Exam per calendar year
	Children's glasses	No Charge Deductible does not apply	No Charge Deductible does not apply	No dollar maximum limits for Pediatric Eyewear
	Children's dental check-up	Not Covered	Not Covered	Separate Dental plan offered

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.)

- Bariatric surgery (except for clinically severe obesity in accordance with plan criteria, which includes second surgical opinion and a one-year physician-supervised, documented weight loss program)
- Cosmetic surgery
- Dental care (Adult & Child) unless elected separately
- Hearing Aids
- Long-term care
- Private- duty nursing
- Routine foot care
- Weight loss programs (except for clinically severe obesity in accordance with plan criteria

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

- Acupuncture
- Routine eye care (Adult)
- Non-emergency care when traveling outside the U.S. unless travel is for sole purpose of obtaining medical services
- Chiropractic care (including the detection and correction of misalignment or subluxation of the vertebral column. Therapy performed to stabilize a chronic condition or prevent deterioration is not covered. Maintenance therapy that seeks to prevent disease, promote health, prolong life, and enhance the quality of life is not covered). Limited to 30 visits.
- Infertility ($5,000 max for and $2,000 max for medical per family per lifetime)

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; 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.

*For more information about limitations and exceptions, see plan or policy document at www.excellusbcbs.com

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	$500
Copayment	$25
Hospital (facility) copayment	$100
Other coinsurance	15%

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

Total Example Cost	**$12,820**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$110
What isn't covered	
Limits or exclusions	$80
The total Peg would pay is	**$690**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Copayment	$25
Hospital (facility) copayment	$100
Other coinsurance	15%

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

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$370
The total Joe would pay is	**$1,370**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Copayment	$25
Hospital (facility) copayment	$100
Other coinsurance	15%

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

Total Example Cost	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$380
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$880**

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

Notice of Nondiscrimination

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.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atenci6n: Si habla espafiol, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

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Attenzione: Se la vostra lingua parlata e l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate ii documento allegato.

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تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez fran<;ais, une assistance linguistique gratuite vous est proposee. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring

sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

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