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, visit ExcellusBCBS.com/sjhsyr.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 https://www.healthcare.gov/sbc-glossary or call 1-877-650-5840 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>Tier 1: $1,500 per member; $3,000 per family Tier 2: $2,500 per member; $5,000 per family Tier 3: $3,500 per member; $7,000 per family (One family member may meet the full family deductible)</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 the deductible?</td>
<td>Yes. Preventive care services (Tier 1 and Tier 2 only) are covered before you meet your deductible.</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>Tier 1: $2,600 per member; $5,200 per family Tier 2: $5,000 per member; $10,000 per family Tier 3: $7,000 per member; $14,000 per family (For family coverage, the noted per member out-of-pocket limits do not apply. Instead, the out-of-pocket limit for any single member is $8,150. Additionally, all members on the contract can contribute to the family out of pocket maximum.)</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>Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services and healthcare the plan does not 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/Sjhsyr.com">www.ExcellusBCBS.com/Sjhsyr.com</a> or call 1-877-650-5840 for a list of network providers.</td>
<td>You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. 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</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
### Important Questions

**see a specialist?**

---

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Tier 1 Providers (You will pay the least)</th>
<th>Tier 2 Providers</th>
<th>Tier 3 Providers (You will pay the most)</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>Primary care visit to treat an injury or illness</td>
<td>10% after <strong>deductible</strong></td>
<td>20% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
<td>——none———</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% after <strong>deductible</strong></td>
<td>20% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
<td>——none———</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>0%, <strong>deductible</strong> waived</td>
<td>0%, <strong>deductible</strong> waived</td>
<td>40% after <strong>deductible</strong></td>
<td>Age and frequency limits may apply.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% after <strong>deductible</strong></td>
<td>20% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
<td>——none———</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% after <strong>deductible</strong></td>
<td>20% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
<td>To be eligible for coverage, these services may require approval before they are provided.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply) 20% after <strong>deductible</strong></td>
<td>Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply) 20% after <strong>deductible</strong></td>
<td>Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply) 20% after <strong>deductible</strong></td>
<td>Certain generic preventive drugs are covered at 100%. No contraceptive coverage. Step therapy program applies. Colleague discounts may apply when prescriptions filled at Trinity Health on-site pharmacies. <strong>Deductible</strong> and OOPM based on Tier 1 benefit level</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply) 20% after <strong>deductible</strong></td>
<td>Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply) 20% after <strong>deductible</strong></td>
<td>Retail (34-day supply), RHM owned pharmacies (34- and 90-day supply) and Mail Order (90-day supply) 20% after <strong>deductible</strong></td>
<td>Certain generic preventive drugs are covered at 100%. No contraceptive coverage. Step therapy program applies. Colleague discounts may apply when prescriptions filled at Trinity Health on-site pharmacies. <strong>Deductible</strong> and OOPM based on Tier 1 benefit level</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Retail (34-day supply),</td>
<td>Retail (34-day supply),</td>
<td>Retail (34-day supply),</td>
<td>Certain generic preventive drugs are covered at 100%. No contraceptive coverage. Step therapy program applies.</td>
</tr>
</tbody>
</table>

---

* For more information about limitations and exceptions, see the plan or policy document at [www.excellusbcbs/sjhsyr.com](http://www.excellusbcbs/sjhsyr.com)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tier 1 Providers (You will pay the least)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 2 Providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 3 Providers (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% after <strong>deductible</strong></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Physician/surgeon fees</td>
<td>10% after <strong>deductible</strong></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% after <strong>deductible</strong></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>10% after <strong>deductible</strong></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Initial visit to determine</td>
<td></td>
</tr>
</tbody>
</table>

**Specialty drugs**

- Same as non-preferred brand drugs
- Same as non-preferred brand drugs
- Not covered

**Tier 1 deductible, coinsurance and OOPM apply to all tiers when ER visit results in admission. Applicable tier deductible, coinsurance and OOPM will apply to non-emergency use of the emergency room.**

**Tier 1 deductible, coinsurance and OOPM apply when Tier 2 providers are used.**

**Tier 1 deductible, coinsurance and OOPM apply when Tier 2 providers are used.**

**Tier 1 deductible, coinsurance and OOPM apply when Tier 2 providers are used.**

**Tier 1 deductible, coinsurance and OOPM apply to all tiers.**

**Tier 1 deductible, coinsurance and OOPM apply to all tiers.**

**Tier 1 deductible, coinsurance and OOPM apply to all tiers.**

**Specialty medications must be filled at a Trinity Health pharmacy or through the OptumRx Specialty program. Specialty drug prescriptions are limited to a 30-day supply. Step therapy program may apply.**

**If you have outpatient surgery**

- Facility fee (e.g., ambulatory surgery center)
  - 10% after **deductible**
  - $100 **copay** then 20% after **deductible**
  - $200 **copay** then 40% after **deductible**

- Physician/surgeon fees
  - 10% after **deductible**
  - 20% after **deductible**
  - 40% after **deductible**

**If you need immediate medical attention**

- Emergency room care
  - 10% after **deductible**
  - 10% after **deductible**
  - 10% after **deductible**

- Emergency medical transportation
  - 10% after **deductible**
  - 10% after **deductible**
  - 10% after **deductible**

- Urgent care
  - 10% after **deductible**
  - 10% after **deductible**
  - 10% after **deductible**

**If you have a hospital stay**

- Facility fee (e.g., hospital room)
  - 10% after **deductible**
  - $500 **copay** then 20% after **deductible**
  - $1,000 **copay** then 40% after **deductible**

- Physician/surgeon fees
  - 10% after **deductible**
  - 20% after **deductible**
  - 40% after **deductible**

**If you need mental health, behavioral health, or substance abuse services**

- Outpatient services
  - 10% after **deductible**
  - 10% after **deductible**
  - 40% after **deductible**

- Inpatient services
  - 10% after **deductible**
  - 10% after **deductible**
  - $1,000 **copay** then 40% after **deductible**

**If you are pregnant**

- Office visits
  - Initial visit to determine
  - Initial visit to determine
  - 40% after **deductible**

[* For more information about limitations and exceptions, see the plan or policy document at www.excellusbcbs/sjhsyr.com.]*
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tier 1 Providers (You will pay the least)</td>
<td>Tier 2 Providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>pregnancy 10% after deductible, then no charge, deductible waived for additional visits</td>
<td>pregnancy 20% after deductible, then no charge, deductible waived for additional visits</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>10% after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>10% after deductible</td>
<td>$500 copay, then 20% after deductible</td>
<td>$1,000 copay, then 40% after deductible</td>
</tr>
</tbody>
</table>

If you need help recovering or have other special health needs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tier 1 Providers (You will pay the least)</td>
<td>Tier 2 Providers</td>
</tr>
<tr>
<td>Home health care</td>
<td>10% after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>10% after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>10% after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% after deductible</td>
<td>$500 copay, then 20% after deductible</td>
<td>$1,000 copay, then 40% after deductible</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% after deductible</td>
<td>10% after deductible</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>
| Hospice services                          | 0%, deductible waived | 0%, deductible waived | 40% after deductible | Limited to 120 maximum days per member per calendar year. Pre-certification required. No coverage under Tier 3 except for autism diagnosis.

If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tier 1 Providers (You will pay the least)</td>
<td>Tier 2 Providers</td>
</tr>
<tr>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.):

- Acupuncture
- Children's dental check-up
- Children's eye exam
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside U.S.
- Routine eye care (adult)

[* For more information about limitations and exceptions, see the plan or policy document at www.excellusbcbs/sjhsyr.com.]

Page 4 of 6
## Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Infertility treatment
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Private-duty nursing
- Chiropractic care (20 max visits per calendar yr)

---

### 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: 1-866-444-4EBSA (3272) or www.dol.gov/ebsa/healthreform or you may contact the plan at 1-877-650-5840. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

### Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: www.ExcellusBCBS.com/Sjhsyr.com or call 1-877-650-5840.

### 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 1-877-650-5840.]
- [Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-650-5840.]
- [Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-650-5840.]
- [Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijgo holne’ 1-877-650-5840.]

---

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

---

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

*[For more information about limitations and exceptions, see the plan or policy document at www.excellusbcbs/sjhsyr.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 $1,500
- Primary copay/Specialist copay 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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

Total Example Cost $12700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$1500</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>$1113</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $60

The total Peg would pay is $2673

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

- The plan’s overall deductible $1,500
- Primary copay/Specialist Copay 10%
- Hospital (facility) coinsurance 10%
- Other 10%

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

Total Example Cost $5400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$1500</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>$380</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $0

The total Joe would pay is $1880

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

- The plan’s overall deductible $1500
- Primary copay/Specialist copay 10%
- Hospital (facility) cost sharing 10%
- Other cost sharing 10%

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

Total Example Cost $1925

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$1500</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>$43</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $0

The total Mia would pay is $1543

Note: If you are also covered by an account-type plan such as a health savings account (HSA), you may have access to additional funds to help cover certain out-of-pocket expenses like the deductible, copays, or coinsurance, or benefits not otherwise covered.