Excellus BCBS: Simply Blue Hybrid

A nonprofit independent licensee of the BlueCross BlueShield Association

Coverage Period: 01/01/2024 - 12/31/2024

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?	$400 Individual/$800 Two Person/$1,200 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: $2,300 Individual/$4,600 Two Person/$6,900 Family; Out-of-Network: $2,530 Individual/$5,060 Two Person/ $7,590 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Costs for premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	$30 Copay/visit Deductible does not apply	40% Coinsurance	No charge for Members to age 19
	Specialist visit	$50 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	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 year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: $50 Copay/visit X-Ray: Deductible does not apply Blood Work: No Charge Blood Work: Deductible does not apply	X-Ray: 40% Coinsurance Blood Work: 40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	$50 Copay/visit Deductible does not apply	40% Coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Tier 1 (Generic drugs)	N/A		
	Tier 2 (Preferred brand drugs)	N/A	N/A	
	Tier 3 (Non-preferred brand drugs)	N/A	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room care	$150 Copay/visit Deductible does not apply	$150 Copay/visit Deductible does not apply	None
	Emergency medical transportation	$75 Copay/visit Deductible does not apply	$75 Copay/visit Deductible does not apply	None

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Urgent care	$40 Copay/visit Deductible does not apply	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 Copay/visit Deductible does not apply	40% Coinsurance	None
	Inpatient services	20% Coinsurance	40% Coinsurance	
If you are pregnant	Office visits	No Charge	40% Coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	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.
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	No Charge Deductible does not apply	25% Coinsurance	Deductible is limited to $50 Out-of-Network 40 Visits per year limit
	Rehabilitation services	$50 Copay/visit Deductible does not apply	40% Coinsurance	45 Visits per year limit
	Habilitation services	$50 Copay/visit Deductible does not apply	40% Coinsurance	45 Visits per year limit
	Skilled nursing care	20% Coinsurance	40% Coinsurance	45 Days per year limit
	Durable medical equipment	20% Coinsurance	40% Coinsurance	None
	Hospice services	No Charge Deductible does not apply	40% Coinsurance	Family bereavement counseling limited to 5 Visits per year
If your child needs dental or eye care	Children's eye exam	$50 Copay/visit Deductible does not apply	40% Coinsurance	1 Exam per year
	Children's glasses	20% Coinsurance Deductible does not apply	40% Coinsurance Deductible does not apply	1 Pair per plan year
	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	• Dental care (Adult)	• Dental care (Child)
• Long-term care	• Prescription Drugs	• Private-duty nursing
• 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.)t 232 14338 4 -1.9 21875 TD()Tj/MyriadPr 9 n605 9 Tf2Acupunctureate

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 $400
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$100
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	$2,370

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible $400
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
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 $400
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$480
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$740

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