Not Just Coverage. Confidence.

Your Benefit Plan Details

Group Name
Optimax Systems, Inc.

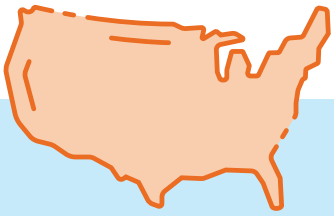
Excellus

Everybody Benefits

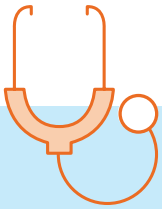
Welcome to Excellus BlueCross BlueShield!

Getting the most from your health plan is more important than ever. Excellus BCBS is here to bring together the coverage, programs and resources you need to be on your way to total physical, emotional and financial wellbeing.

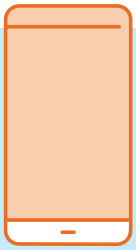
You can count on your Excellus BCBS plan for care when and where you need it:



The area's **largest network of doctors and hospitals,** with greater access close to home and in all 50 states



$0 copays for most preventive services such as an annual routine physical exam*, select vaccines, and important health screenings



Free digital support tools for answers anytime, anywhere, such as:

- Online member account
- Mobile app
- Estimate out-of-pocket medical costs
- Find a doctor, specialist or facility that accepts your plan

Find more answers and support at **ExcellusBCBS.com**

In this booklet you will find:

- A chart that summarizes this plan's unique benefits and coverage**
- Helpful information to help you get the most from your plan
- A glossary of terms to help you understand your coverage and options

* Does not include procedures, injections, diagnostic services, laboratory and X-ray services, or any other services not billed as preventive services.
**This benefit summary is not a contract or binding agreement; it is a summary of benefits and services.

Optimax Systems, Inc.

Signature Deductible $2,000

Plan Features

Primary Care Physician (PCP)	Not Required
Referrals	Not Required
Out of network benefits	Covered
Student / Dependent Coverage	Covered to age 26/26
Domestic Partner	Covered
Coverage Period	01/01/25-12/31/25
Office visit copay (Primary Care Physician)	In-Network: 20% /Out- of- Network: 40%
Office visit copay (Specialist)	In-Network: 20%/Out- of- Network: 40%
Coinsurance	In- Network: 20% / Out-of-Network: 40%
Deductible	In-Network: $2,000 / $4,000 / Out- of- Network: $4,000 / $8,000
Out of pocket maximum	In-Network: 4,000 / $8,000 / Out- of- Network: $8,000 / $16,000

Questions? For assistance call ,
Call our TTYphone at 1 (800) 421-1220,

Excellus

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: $2,000 Individual/ $4,000 Family; Out-of-Network: $4,000 Individual/ $8,000 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 policy, the overall family deductible must be met before the plan begins to pay.
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: $4,000 Individual/$8,000 Family; Out-of-Network: $8,000 Individual/ $16,000 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, the overall family out-of-pocket limit must be 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	20% Coinsurance	40% Coinsurance	None
	Specialist visit	20% Coinsurance	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 calendar year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: 20% Coinsurance Blood Work: 20% Coinsurance	X-Ray: 40% Coinsurance Blood Work: 40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.excellusbcbs.com/rxlist	Tier 1 (Generic drugs)	$5/prescription retail, $10/ prescription mail order No Charge Members to age 19	Not Covered	Covers up to a 30-day supply (retail); 90-day supply (mail order)/prescription Preauthorization required for certain prescription drugs. If you don't get a preauthorization, you must pay the entire cost and submit a claim to us for reimbursement. Accelerated approved drugs are not covered unless the manufacturer participates in the Medication Assurance Program.
	Tier 2 (Preferred brand drugs)	$35/prescription retail, $70/ prescription mail order	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$70/prescription retail, $140/ prescription mail order	Not Covered	
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	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	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	20% Coinsurance	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.

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

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)	
	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	20% Coinsurance	40% Coinsurance	None
	Rehabilitation services	20% Coinsurance	40% Coinsurance	45 Visits per plan year limit
	Habilitation services	20% Coinsurance	40% Coinsurance	45 Visits per plan year limit
	Skilled nursing care	20% Coinsurance	40% Coinsurance	45 Days per plan year limit
	Durable medical equipment	20% Coinsurance	40% Coinsurance	None
	Hospice services	20% Coinsurance	40% Coinsurance	Family bereavement counseling limited to 5 Visits per plan year
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Child)
- 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
- Chiropractic care
- Hearing aids
- Infertility treatment
- 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 https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. 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.

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

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/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa; New York State Department of Financial Services Consumer Assistance Unit at 1-800-342-3736 or www.dfs.ny.gov. 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: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Coinsurance	**20%**
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	$2,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	**$2,000**
Coinsurance	**20%**
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	$2,000
Copayments	$50
Coinsurance	$670
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,740**

Mia's Simple Fracture

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

The plan's overall deductible	**$2,000**
Coinsurance	**20%**
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	$2,000
Copayments	$0
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,160**

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

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Excellus BluePPO Signature Deduct 3

$5/$35/$70 Integrated Rx $0 Generics for Kids Preventive Rx not subject to Deductible

Benefit Time Period: 01/01/2025 - 12/31/2025

Optimax Systems, Inc.

General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Deductible - Single	$2,000	$4,000	
Deductible - Family	$4,000	$8,000	
Coinsurance	20%	40%	
Annual Out of Pocket Maximum - Single	$4,000	$8,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Family	$8,000	$16,000	Out-of-pocket maximums accumulate coinsurance, copays and the deductible. Out-of-pocket maximums exclude balances over allowable expense and non-covered services.
Annual Out of Pocket Maximum - Per Person Cap	$6,650	$16,000	The Out-of-Pocket Maximum Per Person Cap includes deductible, coinsurance, copays and prescription drugs. If a member under a family contract meets the Out-Of-Pocket Maximum Per Person Cap amount, the individual will no longer pay for covered services and claims will be paid at 100% of the allowable amount by the Health Plan for the remainder of the plan year. The remaining annual out-of-pocket maximum still needs to be met by any combination of family members on the contract before claims are paid at 100% for the whole family.

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits and Additional Information
Cost Share - Primary Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Plan/Calendar Year			Plan Year Benefits
Diabetic Preauthorization and Step Therapy			Applies

Who is Covered

Benefit Name	In Network	Out of Network	Limits and Additional Information
Domestic Partner Coverage			Covered

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	
Skilled Nursing Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per plan year Limits are combined INN and OON.
Physical Rehabilitation	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per plan year Limits are combined INN and OON.
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	
Anesthesia	PCP/Specialist - 20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $2,000 Deductible	Includes anesthesia rendered for Inpatient, Outpatient, Office Visit, and Maternity services. Anesthesia does not require a preauth or referral.

Outpatient Facility Services

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	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	20% Coinsurance Subject to Deductible	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	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization
Substance Use Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes Partial Hospitalization

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Home Care	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Home Infusion Therapy	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	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).

Hospice Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Hospice Care Inpatient	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

Benefit Name	In Network	Out of Network	Limits and Additional Information
Office Surgery	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Primary Service	Inclusive of Primary Service	Is inclusive in the Home Care benefit and not covered as a separate benefit.
Dialysis	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Telehealth	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP/Specialist - 0% Coinsurance Subject to Deductible	Not Covered	Covers online internet consultations between the member and the providers who participate in our TeleMedicine MDLive Program for medical and behavioral health conditions that are not emergency conditions.
Chiropractic Care	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Allergy Testing	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Allergy Testing includes injections and scratch and prick tests.
Allergy Treatment Including Serum	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Includes desensitization treatments (injections & serums).
Hearing Evaluations Routine	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per plan year Limits are combined INN and OON.

Rehab and Habilitation

Outpatient Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Physical Rehabilitation	20% Coinsurance Subject to Deductible	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	20% Coinsurance Subject to Deductible	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	20% Coinsurance Subject to Deductible	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 - 20% Coinsurance Subject to Deductible	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 - 20% Coinsurance Subject to Deductible	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 - 20% Coinsurance Subject to Deductible	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 calendar year
Adult Immunizations	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	0% Coinsurance	
Routine GYN Visit	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - Covered in Full	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	
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	

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

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prostate Cancer Screening	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

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

Benefit Name	In Network	Out of Network	Limits and Additional Information
Mammography Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Treatment of Diabetes - Non-Insulin Drugs and Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Treatment of Diabetes - Insulin	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	Limited to a 90 day supply for retail pharmacy or a 90 day supply for mail order pharmacy.
Diabetic Equipment	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Benefit Name	In Network	Out of Network	Limits and Additional Information
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered	Not Covered

Diagnoses

Benefit Name	In Network	Out of Network	Limits and Additional Information
Reimbursement for Travel and Lodging Expenses	PCP/Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits and Additional Information
Facility Emergency Room Visit	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $2,000 Deductible	Prior Authorization may not apply to any emergency care services. Emergency services are covered worldwide if provided by a hospital facility.

Transportation

Benefit Name	In Network	Out of Network	Limits and Additional Information
Prehospital Emergency and Transportation - Ground or Water	20% Coinsurance Subject to Deductible	20% Coinsurance Subject to $2,000 Deductible	

Urgent Care

Benefit Name	In Network	Out of Network	Limits and Additional Information
Urgent Care Center Facility Visit	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits and Additional Information
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits and Additional Information
Rx Plan			$5/$35/$70 Integrated Rx $0 Generics for Kids Preventive Rx not subject to Deductible

Rx Benefits

Benefit Name	In Network	Out of Network	Limits and Additional Information
Days Supply Per Retail Order	30		
Days Supply Per Mail Order	90		
Copays Per Mail Order Supply	2		

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.

Optimax Systems, Inc.

Dental Blue Option

Plan Features

Primary Care Physician (PCP)	Not Required
Referrals	Not Required
Out of network benefits	Not Covered
Student / Dependent Coverage	Covered to age 26/26
Domestic Partner	Covered

Questions? For assistance call ,
Call our TTYphone at 1 (800) 421-1220,

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Dental Blue Options Summary of Benefits

Employer Group name: Optimax Systems, Inc.

Plan Type: Contributory (employer-sponsored)
Product Type: Passive PPO (same coinsurance in & out-of-network)

Plan Features

Network: Reimbursement In network: BlueShield local network Reimbursement Out-of-network: BlueShield (subject to balance billing) Reimbursement Out-of-area In Network: N/A	Dependent / student age limit: 26/26
Annual Plan Deductible: $50 Ind / $150 Fam Deductible applies to: Classes II, IIA and III services	Annual Plan Maximum per member: $2,500 per member Annual Max applies to: Classes II, IIA and III services
Ortho Age Limit: Children to age 19 Lifetime Orthodontia Maximum: $2,000 per member (does not apply toward annual plan maximum)	Annual Maximum Rollover Benefit: No Annual Maximum Rollover Design Rollover Threshold: Not applicable Rollover Amount: Not applicable Rollover Account Max: Not applicable

Plan Benefits

Type of Care	Benefits Included	Excellus BCBS Pays: In-Network	Excellus BCBS Pays: Out-of-Network
Class I Preventive & Diagnostic	• Cleanings & exams - twice per calendar year • Fluoride treatments – twice per calendar year to age 16 • Sealants – unrestored 1st and 2nd permanent molars, once every 36 months • Bitewing x-rays – up to 4 every calendar year • Full mouth/Panoramic x-rays – once every 36 months • Diagnostic Photograph/Facial Images – once per calendar year • Space maintainers – up to age 16 • Emergency palliative treatment	100%	100%
Class II Basic Restorative	• Fillings – amalgam & composite; each surface covered once every 12 months • Oral surgery – simple extractions	80%	80%
Class IIA Basic Restorative 12-month waiting periods apply on voluntary plans to late entrants only	• Oral surgery – surgical extractions • Endodontics – root canal treatment • Periodontal surgery – osseous surgery, gingivectomy, gingival flap procedure – covered once per quadrant every 36 months • Periodontal scaling & root planing – once per quadrant every 24 months	80%	80%

This is not a contract or binding agreement; it is a summary of benefits and services. For complete details, please refer to your member contract.

	• Periodontal maintenance following surgery – twice per calendar year		
Type of Care	**Plan Benefits**	**In-Network**	**Out-of-Network**
Class III Major Restorative 12-month waiting periods apply on voluntary plans to late entrants only	• Fixed prosthetics – bridgework, abutments, pontics • Removable prosthetics – partial / complete dentures • Inlays / onlays / crowns – includes coverage for re-cementation • Relines / rebases – once every 36 months and at least 6 months following initial placement • Above services eligible for replacement every 5 years • Implants – eligible for replacement every 10 years, and subject to alternate benefits provision	50%	50%
Class IV Orthodontia 12-month waiting periods apply on voluntary plans to late entrants only	• Initial banding & monthly follow-up treatment • No more than 1/2 the lifetime maximum can be paid in any calendar year	50%	50%

How to Get The Most From Your Plan

Pre-determination of Benefits

Pre-determination of benefits is recommended for any extensive treatment such as periodontics, orthodontics or prosthetics. A description of planned treatment and expected charges should be sent to the Plan before treatment is started. If there is a major change in the treatment, a revised predetermination of benefits is required. The expenses that will be included as Covered Expenses will be determined by your Plan and are subject to the Alternate Benefit provision. When there has not been a predetermination of benefits, your Plan will determine the expenses that will be included as Covered Expenses at the time the claim is received. Predetermination of Benefits does not guarantee payment and expires one year from date of issue. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

Alternate Benefits Provision

All covered procedures are subject to an alternate benefit allowance. When there is more than one technology or material type for a dental procedure, the dental plan will reimburse for the procedure which has the lesser allowance. When alternate benefit is enforced, your benefits are not intended to interfere with the treatment plan recommended by the dentist. You and your dentist should discuss which treatment is best suited for you, and may proceed with the original treatment plan regardless of benefit determination. If the more expensive treatment is chosen, you are liable for the balance up to the billed amount.

Waiting Periods – Timely Entrants

Timely Entrants are those employees that join the plan within 31 days of the following events: During initial open enrollment with Excellus (for new dental groups), As a new hire, After a qualifying event

Participating Dentists

Excellus BlueCross BlueShield offers a broad participating dental network in the Rochester, Syracuse, Utica and surrounding areas. You have the option of receiving care from a dentist of your choice. However, choosing a participating dentist may result in savings for you because participating dentists agree to accept our Schedule of Allowances as payment in full for covered services. Aside from any coinsurance, there is no balance billing for covered services when provided by a participating dentist – that's full coverage with no out-of-pocket expense for your covered routine preventive and diagnostic services.

Non-participating Dentists

You have the freedom to see any dentist. Non-participating dentists are not obligated to accept our Schedule of Allowances. You will be responsible for balances of non-participating dentists' charges.

This is not a contract or binding agreement; it is a summary of benefits and services. For complete details, please refer to your member contract.

National Dental Network (if applicable)
In addition to our local network, your Excellus BlueCross BlueShield dental plan gives you access to more dentists nationwide. The national dental network offers coverage in all 50 states, with access to an additional 123,000+ providers across the nation. You have the option of receiving care from a dentist of your choice. Choosing a participating dentist may result in savings for you because participating dentists agree to accept the national dental network Schedule of Allowances as payment for covered services. Aside from any coinsurance, there is no balance billing for covered services when provided by a participating dentist- that's full coverage with no out-of-pocket expense for your covered routine preventive and diagnostic services.

Annual Maximum Rollover Benefit (if applicable)
You can roll over a portion of your unused amount in your annual maximum to the next year if you submit at least one paid dental claim, and do not exceed the rollover threshold. Funds that roll over are added to the next year's annual maximum to be used for future treatment.

Dental Customer Service – for members and dentists
1-800-724-1675
Hours: Monday – Thursday 8:00 am – 5:30 pm
Friday 9:00 am – 5:30 pm

Mailing address for claims
Excellus BCBS
PO Box 21146
Eagan, MN 55121

Excellus | Blue365

A nonprofit independent licensee of the Blue Cross Blue Shield Association

HEALTHY LIVING IS JUST A DEAL AWAY

Join Blue365 and start saving today!

Blue365 gives you access to savings across all aspects of your life– including 20 percent off on Fitbit devices and over $800 off Lasik, discounts on healthy, organic meal delivery services like Sun Basket, and much more!

Register now for free to take advantage of Blue365. It's an online destination where participating members can find healthy deals and exclusive discounts, all you need is your Excellus BlueCross BlueShield member card to get started.

Get started today at
www.Blue365Deals.com/register

Exclusive savings from

fitbit
GARMIN
SKECHERS
Hotels.com
American HEARING BENEFITS
SUN BASKET
KIND
eyeMed

Understanding Your
HIGH DEDUCTIBLE HEALTH PLAN

A high deductible health plan or "HDHP" is designed to help keep premium costs low for you and your family. You'll have coverage for things like:

- Choice of doctors and hospitals
- Doctor visits
- Free preventive care
- Hospitalization
- Laboratory coverage
- Maternity and newborn care
- Prescription drug
- Specialty care
- Urgent care visits

Let's start with the basics:

Preventive care can help you avoid getting sick and improve your health. With a HDHP, preventive services such as routine physicals, screenings and vaccinations are covered in full.* The deductible does not apply to preventive services; they are covered in full from day one.

For services other than preventive care, you are responsible for paying out of your pocket until you meet your **deductible**. The deductible amount will vary based on your plan, so make sure you know what that amount is. Once you reach your deductible, you will pay a percentage of cost, called coinsurance. **Coinsurance** is your share of the costs of a covered health care service, calculated as a percent. You will have to pay a percentage of that service and the health insurance company will pay the rest.

THE DIAGRAM ILLUSTRATES HOW THIS WORKS:**

<table>
<tr><th rowspan="2">Preventive Services</th><th colspan="3">Other Services</th></tr>
<tr><th>Until deductible amount is reached</th><th colspan="2">After deductible amount is reached</th></tr>
<tr><td>Health Insurance Company Pays
100%</td><td>You pay
100%</td><td>You pay
20%</td><td>Health Insurance Company Pays
80%</td></tr>
<tr><td>Insurance company provides full coverage</td><td>You pay a deductible up to a certain amount</td><td colspan="2">Once the deductible amount is reached, you pay a percentage called coinsurance</td></tr>
</table>

You can use a tax-free account called a Health Savings Account (HSA) to help pay for your portion of the costs. Talk to your HR or benefits representative about the account options that might be available to you.

*In accordance with the PPACA preventive care regulations, full coverage (no cost share) will be applied for those services meeting the requirements as outlined in Grade A and B Recommendations of the United States Preventive Services Task Force.

**note: for illustrative purposes only- plan options vary

Here's how it works:

Let's say your deductible is **$2,000.**

You go to your doctor for low back pain.
You pay $100 for the visit.

You still have to pay **$1900** more to reach your deductible.

Your doctor orders an MRI of your lower back.
You pay $1,000 for the MRI.

You still have to pay **$900** more to reach your deductible.

After a series of visits to your doctor and a chiropractor, you have **$0** left to reach your deductible. Now you will pay a percentage of cost, **called coinsurance**.

If your coinsurance is **20%**, and the next time you visit your doctor your bill is **$100**, then **you'll pay $20 and we will pay $80.**

To help you with your costs, there is an **out-of-pocket maximum** which is an annual limit on the amount of money that you would have to pay for health care services, not including your monthly premiums. Remember, preventive care is covered in full and is not subject to the deductible.

To determine your deductible, out-of-pocket maximum and coinsurance amounts, check your Summary of Benefits and Coverage (SBC), your online member account at Member.ExcellusBCBS.com, or your monthly health statements.

How much will you pay?

A lot goes into that. First, is how much your provider charges for a service. At Excellus BCBS, we've negotiated with providers so our members pay less than if you went to your doctor uninsured.

There are a few other things you can do to help figure out how much you're going to pay when you need care:

1. Use our **Estimate Medical Costs** tool at ExcellusBCBS.com/EstimateCosts. This tool provides an estimate of what a procedure might cost among different providers. For personalized results based on your benefits, use the tool while logged in to your member account.
2. **Call your doctor or specialist** ahead of time and ask how much the anticipated service will cost.
3. Log into your member account at **Member.ExcellusBCBS.com** to check your benefits or call our Customer Care Advocates at the number listed on the back of your member card.

Visit our website at **ExcellusBCBS.com/HighDeductible** for more information and easy-to-use tools and cost calculators.

B-7401 / 15926-22M

PRESCRIPTION HOME DELIVERY

SIGNING UP IS AS EASY AS 1, 2, 3

STEP 1

Call a pharmacy

Wegmans Home Delivery: **(800) 586-6910**
or visit Wegmans.com/Pharmacy
Express Scripts: **(855) 315-5220**
or visit Express-Scripts.com

STEP 2

Speak to a representative

STEP 3

Rx delivered right to your mailbox

Consider home delivery if you:

- → **Would like to receive a 90-day supply all at once.**
- → **Take the same medication(s) every month.**
- → **Need help managing your family's prescriptions.**

Home delivery of prescriptions is safe and confidential

- Insulated packaging protects your medications from the sun, rain and cold.
- Discreet packaging does not reveal contents.
- Delivery straight to your mailbox.

Automatic refill option. Free standard shipping. Express delivery available. Pharmacists available to answer questions.
Call today!

Excellus | Everybody Benefits

B-6342/17934-23Rx REV 07/23

PEACE OF MIND. FREE OF CHARGE.

SCHEDULE YOUR ANNUAL CHECKUP TODAY

Stay a step ahead of future health issues by staying on top of your routine checkups today.

✓ PREVENTIVE CARE KEEPS YOU HEALTHY. AND IT'S COVERED.*

- Annual Routine Checkup
- Annual OB/GYN Visit
- Cholesterol Screening
- Colorectal Cancer Screening
- Diabetes (Type 2) Screening
- Immunizations
- Mammography Screening
- Well-Child Visit

See the full list of preventive care services available to you at
ExcellusBCBS.com/PreventiveCare

Download the Excellus BCBS app and register your online account.

Download on the App Store | GET IT ON Google Play

*A well visit or preventive service can sometimes turn into a "sick visit," in which out-of-pocket expenses for deductible, copay and/or coinsurance may apply. There may also be other services performed in conjunction with the above preventive care services that might be subject to deductible, copay and/or coinsurance. Does not include procedures, injections, diagnostic services, laboratory and X-ray services, or any other services not billed as preventive services.

B-7332/15926-22M

Telemedicine for Medical and Behavioral Health Care

THE DOCTOR WILL SEE YOU NOW. WHEREVER. WHENEVER.

If your doctor isn't available, telemedicine may be an option for you. 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, via your phone, tablet, or computer.

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
- Nausea and Vomiting
- Pink Eye
- Rashes
- Sinus Infections
- Sunburn
- Urinary Tract Infections*

Children

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

Excellus

*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.

Telemedicine is good for the mind as well as the body.

In addition to whenever, wherever access to medical doctors, you can also consult 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.

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 visits with MDLIVE may be covered in the following ways:

Plan Type	Telemedicine Cost Share
Copay	Covered in full
Hybrid / Deductible Non-HSA	If your doctor's visits are subject to deductible, a telemedicine visit will be covered in full after deductible
	If your doctor's visits are a copay with no deductible, a telemedicine visit will be covered in full
Deductible HSA	Covered in full after deductible
Note: This is not a contract. It is intended to highlight the coverage for most plan options. Please refer to your contract for your plan's benefits.	

*If you haven't met your deductible, you will pay the allowable charge of $50. The allowable charge does not apply to Behavioral Health services. The allowable costs for the Behavioral Health services vary but do not exceed $180. This means a member who has not met their deductible will not pay more than $180.

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 - EXCELLUS to 635483 (Message and data rates may apply.)
VOICE - Call 1-866-692-5045

DID YOU KNOW?

of doctor's office visits could be handled over the phone.[1]

days is the average wait time between scheduling an appointment and seeing a primary care doctor.[2]

of emergency room visits can potentially be prevented with telemedicine.[3]

[1] "New medical cost savings program: Telemedicine means great discounts." R. Schultz, January 9, 2010.

[2] Based on MDLIVE data, 2016.

[3] Based on New York State Department of Health data, 2016.

MDLIVE does not replace the primary care physician. MDLIVE is not an insurance product. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services. MDLIVE phone consultations are available 24/7/365, while video consultations are available during the hours of 7 am to 9 pm ET 7 days a week or by scheduled availability. MDLIVE and the MDLIVE logo are registered trademarks of MDLIVE, Inc. and may not be used without written permission. For complete terms of use and privacy policy, please visit www.mdlive.com/terms-of-use and www.mdlive.com/privacy-policy. MDLIVE is an independent company, offering telehealth services in the Excellus BlueCross BlueShield service area.

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, origin, age, disability, or sex.

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

注意 ：如果您说中文 ，我们可为您提供免费的语言协助 。请参见随附的文件以获取我们的联系方式 。

B-6675 / 17633-23M REV 04/23

Excellus

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

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: 1-315-671-6656

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, 1-800-537-7697 (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.

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

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

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

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

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 français, une assistance linguistique gratuite vous est proposée. 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.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

B-5495

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 percentage of the allowed amount for certain medical services.

Deductible

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

Out-of-pocket maximum

The maximum amount of copays, 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.

Excellus BlueCross BlueShield

Everybody Benefits

A nonprofit independent licensee of the Blue Cross Blue Shield Association

18369-23M