

## Excellus BCBS: Excellus BluePPO Signature Deduct 3

Coverage Period: 01/01/2025 - 12/31/2025

A nonprofit independent licensee of the BlueCross BlueShield Association

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.excellusbcb.com](http://www.excellusbcb.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](http://www.cciio.cms.gov) or [www.healthcare.gov/sbc-glossary](http://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 <a href="#">deductible</a> ?	In-Network: \$2,500 Individual/ \$5,000 Family; Out-of-Network: \$5,000 Individual/ \$10,000 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, <a href="#">Preventive Care</a>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-Network: \$5,000 Individual/\$10,000 Family; Out-of-Network: \$10,000 Individual/ \$20,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Costs for <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.excellusbcb.com">www.excellusbcb.com</a> or call 1-800-499-1275 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge <a href="#">Deductible</a> does not apply	Adult Physical: 40% <a href="#">Coinsurance</a> Adult Immunizations: 40% <a href="#">Coinsurance</a> Well Child Visit: No Charge	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. 1 Exam per calendar year
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-Ray: 20% <a href="#">Coinsurance</a> Blood Work: 20% <a href="#">Coinsurance</a>	X-Ray: 40% <a href="#">Coinsurance</a> Blood Work: 40% <a href="#">Coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.excellusbcbs.com/rxlist">www.excellusbcbs.com/rxlist</a>	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 <a href="#">Preauthorization</a> required for certain <a href="#">prescription drugs</a> . If you don't get a <a href="#">preauthorization</a> , you must pay the entire cost and submit a claim to us for reimbursement.
	Tier 2 (Preferred brand drugs)	\$45/prescription retail, \$90/prescription mail order	Not Covered	
	Tier 3 (Non-preferred brand drugs)	\$90/prescription retail, \$180/prescription mail order	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">Coinsurance</a>	20% <a href="#">Coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">Coinsurance</a>	20% <a href="#">Coinsurance</a>	None
	<a href="#">Urgent care</a>	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	None
	Physician/surgeon fees	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	None
	Inpatient services	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	
<b>If you are pregnant</b>	Office visits	No Charge	40% <a href="#">Coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .

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% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.). Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply.
	Childbirth/delivery facility services	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	None
	<a href="#">Rehabilitation services</a>	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	45 Visits per plan year limit
	<a href="#">Habilitation services</a>	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	45 Visits per plan year limit
	<a href="#">Skilled nursing care</a>	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	45 Days per plan year limit
	<a href="#">Durable medical equipment</a>	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	None
	<a href="#">Hospice services</a>	20% <a href="#">Coinsurance</a>	40% <a href="#">Coinsurance</a>	Family bereavement counseling limited to 5 Visits per plan year
<b>If your child needs dental or eye care</b>	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](#).)**

- |                            |                        |                            |
|----------------------------|------------------------|----------------------------|
| • 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.)**

- |                |                         |                                                      |
|----------------|-------------------------|------------------------------------------------------|
| • Acupuncture  | • 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](http://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.excellusbcbcs.com](http://www.excellusbcbcs.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](http://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](http://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](mailto:cha@cssny.org) or [www.communityhealthadvocates.org](http://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](http://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](#) \$2,500
- [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
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**In this example, Peg would pay:**

Cost Sharing	
Deductibles	\$2,500
Copayments	\$10
Coinsurance	\$2,010
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,580

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$2,500
- [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
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**In this example, Joe would pay:**

Cost Sharing	
Deductibles	\$2,500
Copayments	\$40
Coinsurance	\$570
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3,130

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

- The [plan's](#) overall [deductible](#) \$2,500
- [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
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**In this example, Mia would pay:**

Cost Sharing	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$60
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,560