Carrols Corporation
Health Insurance and Prescription Coverage
At A Glance

Blue Cross Blue Shield
PPO – Blue Preferred PLAN 1

Eligibility	• If you wish to participate in the medical plan, enrollment is required • Your Eligible Dependent Child(ren) may be covered under your plan up to age 26 • Coverage for Domestic Partners
Plan Design	• Preferred Provider Organization Plans - A network of professional providers who have a written agreement with Blue Cross Blue Shield to provide services under the PPO arrangement. • One identification card for both the medical plan and prescription plan
Employee Contribution Level	• **See Weekly Rate sheet located on the Home Page of your Benefits Communication Portal.** • **When electing your benefits on the Benefits Enrollment Portal your weekly deductions will be calculated for you in your cart summary on the right side of the screen.**
Health Plan In-Network Benefit	• Calendar year deductible – $0.00/Individual and $0.00/Family • Co-payment for Office visits – $25.00 • Co-payment for Specialist visits – $35.00 • 20% Co-insurance (unless otherwise noted) • Emergency Room Visit - $400.00 co-pay • Urgent Care Center - $75.00 co-pay • In-Patient Facility Services - $450.00 co-pay /In-Network • Out of Pocket Limits - $3,000/Individual and $9,000/Family • Out of Pocket Maximums – apply to co-payments and co-insurance • Pre-authorization required for In-patient admissions, home health care and durable medical equipment*
Health Plan Out-of-Network Benefit	• Calendar year deductible – $250.00/Individual and $750.00/Family • 30% Co-insurance after deductible is met (unless otherwise noted) • Co-payment for Office visits – 30% co-insurance after deductible is met • Co-payment for Specialist visits – 30% co-insurance after deductible is met • Emergency Room Visit - $400.00 co-pay • Urgent Care Center – 30% co-insurance after deductible is met • In-Patient Co-Pay – 30% co-insurance after deductible is met • Out of Pocket Limits - $4,000/Individual and $12,000/Family

TELEMEDICINE	• BCBS Partnered with MDLIVE • Access to U.S. Board Certified physicians 24/7/365 via telephone and videoconference • Alternative to seeking non-emergency medical care if your primary care physician is not available • Save time and money by using Telemedicine rather than the Emergency Room or Urgent Care center. • Doctors can diagnose your symptoms, prescribe medication and send the prescription to your nearest pharmacy. • Registration required • $10.00 co-pay required at time of initial call. Payment via a credit card or Flexible Spending Account Healthcare payment card. • www.excellusbcbs.com/telemedicine or telephone 1-866-692-5045 **Common conditions treated** • **Allergies** • **Asthma** • **Bronchitis** • **Cold & Flu** • **Sinus infections** **……and more!**

Additional Health Plan benefits	• You may enroll your adult child up to age 26 in your Medical plan regardless of their student status or marital status.
	• Some essential benefits which do not require a co-pay or co-insurance are:
	  • Well Child Visits up to Age 21
	  • Immunizations
	  • Mammograms
	  • Annual physical
	For the full list of essential benefits, contact Blue Cross Blue Shield

PRESCRIPTION COVERAGE	• One identification card for your health insurance and prescriptions • Retail network pharmacies and mail-order option • Pay retail co-payment for each prescription for 30-day supply of medications • Mail Order: pay up to two (2) co-payments for 90-day supply • Select Home Delivery – Maintenance medications filled via mail order • Dispense as Written (DAW) – Generic filled when available
Prescription Co-payments	• Retail pharmacy: Generic medications $20.00 co-pay, preferred $45 co-pay, or brand name $55 co-pay • Mail-order: Generic medications $35 co-pay, preferred $90 co-pay, or brand name $110 co-pay for a 90-day supply of maintenance prescriptions.

Non-Network Pharmacy	• Employee must pay for the prescription at the time of service directly to the pharmacy and submit a reimbursement claim directly to Blue Cross Blue Shield. Blue Cross Blue Shield may reimburse the drug cost at the network pharmacy level. Not all prescriptions will receive a reimbursement.
Home Delivery Mail Order Incentive	• Home Delivery/Mail Order Incentive – Members who take maintenance medications are encouraged to use the mail order process to refill their monthly maintenance prescriptions. Members will be notified of the new Home Delivery process when refilling maintenance drugs at the retail level by Express Scripts. A member may continue to refill their maintenance medications at the Retail level rather than move to Mail Order, they will pay their co-pay for that prescription, plus an additional 20% co-pay charge. • Members will need to contact their doctor to obtain a new prescription for a 90 day mail order supply.
Dispense As Written (DAW)	• Dispense as Written (DAW) program. When a prescription is written and you go to either a retail pharmacy or mail order to fill it, **if** there is a generic drug available for the drug prescribed to you, the prescription will be filled with the generic. If you choose **not** to take the generic available you may be subject to additional co-pay fees. On an individual and drug by drug case Express Scripts will be happy to work with you and your physician to ensure that you are receiving the necessary medication, generic or brand. This also will save you money by paying the Generic premium versus a Brand or Non-Preferred Brand co-pay.

***Pre-Approval (applies to Medical Plan)**

Pre-Approval is required for all In-Patient admissions and home health care. For elective admissions, call at least 7 days prior and emergency admissions call within 2 business days. A penalty of $500 or more will be imposed if you do not comply with the pre-approval requirements. This is in addition to the In-Patient Co-Pay. To complete the pre-approval, call customer service at 1-800-462-6615. Services related to mental health and alcohol/substance abuse will be referred to Excellus Behavioral Health Services, Inc. 1-800-649-6646.

Website: Medical and Prescription – www.bcbs.com or (800) 734-4069

Carrols Corporation
Health Insurance and Prescription Coverage
At A Glance

Blue Cross Blue Shield
HDHP – PLAN 2 for Team Members

Eligibility	• If you wish to participate in the medical plan, enrollment is required • Your Eligible Dependent Child(ren) may be covered under your plan up to age 26 • Coverage for Domestic Partners
Plan Design	• High Deductible Health Plans - A plan with a higher deductible and lower premiums • One identification card for both the medical plan and prescription plan
Employee Contribution Level	• **See Weekly Rate sheet located on the Home Page of your Benefits Communication Portal.** • **When electing your benefits on the Benefits Enrollment Portal your weekly deductions will be calculated for you in your cart summary on the right side of the screen.**
Health Plan In-Network Benefit	• Calendar year deductible – $2,600/Individual and $5,200/Family • 20% Co-insurance after deductible is met • Co-payment for Office visits – 20% co-insurance after deductible is met • Co-payment for Specialist visits – 20% co-insurance after deductible is met • Emergency Room Visit – 20% co-insurance after deductible is met • Urgent Care Center - 20% co-insurance after deductible is met • In-Patient Co-Pay – 20% co-insurance/In-Network • Out of Pocket Limits - $4,000/Individual and $8,000/Family • Out of Pocket Maximums – apply to co-payments and co-insurance • Pre-authorization required for In-patient admissions, home health care and durable medical equipment*
Health Plan Out-of-Network Benefit	• Calendar year deductible – $5,200/Individual and $10,400/Family • 40% Co-insurance after deductible is met (unless otherwise noted) • Co-payment for Office visits – 40% co-insurance after deductible is met • Co-payment for Specialist visits – 40% co-insurance after deductible is met • Emergency Room Visit - 40% co-insurance after deductible is met • Urgent Care Center – 40% co-insurance after deductible is met • In-Patient Co-Pay – 40% co-insurance after deductible is met • Out of Pocket Limits - $8,000/Individual and $16,000/Family

Additional Health Plan Benefits	• You may enroll your adult child up to age 26 in your Medical plan regardless of their student status or marital status.
	• Some essential benefits which do not require a co-pay or co-insurance are:
	  • Well Child Visits up to Age 21
	  • Immunizations
	  For the full list of essential benefits, contact Blue Cross Blue Shield
	• If one person meets the individual deductible while enrolled in a two-person or family plan, they can begin paying co-insurance. Family out of pocket still applies.

TELEMEDICINE	• BCBS Partnered with MDLIVE • Access to U.S. Board Certified physicians 24/7/365 via telephone and videoconference • Alternative to seeking non-emergency medical care if your primary care physician is not available • Save time and money by using Telemedicine rather than the Emergency Room or Urgent Care center. • Doctors can diagnose your symptoms, prescribe medication and send the prescription to your nearest pharmacy. • Registration required • $40.00 co-pay required at time of initial call. Payment via a credit card or Health Savings Account payment card. • www.excellusbcbs.com/telemedicine or telephone 1-866-692-5045 **Common conditions treated** • **Allergies** • **Asthma** • **Bronchitis** • **Cold & Flu** • **Sinus infections** **……and more!**
PRESCRIPTION COVERAGE	• One identification card for your health insurance and prescriptions • Retail network pharmacies and mail-order option • Prescriptions are subject to the plan's deductible • Integrated Rx with Preventative Rx • Drugs included on the Preventative Drug List are subject to co-payment. All other drugs are subject to the overall plan deductible. • Pay one (1) co-payment for each prescription for 30-day supply • Mail Order: pay up to two (2) co-payments for 90-day supply • Select Home Delivery – Maintenance medications filled via mail order
Prescription Co-payments	• Prescriptions are subject to the plan's deductible • Drugs included on the Preventative Drug List are subject to the following co-payments: • Retail pharmacy: Generic medications $5 co-pay, preferred $35 co-pay, or brand name $70 co-pay • Mail-order: Generic medications $10 co-pay, preferred $70 co-pay, or brand name $140 co-pay for a 90- day supply
Non-Network Pharmacy	Employee must pay for the prescription at the time of service directly to the pharmacy and submit a reimbursement claim directly to Blue Cross Blue Shield. Blue Cross Blue Shield may reimburse the drug cost at the network pharmacy level. Not all prescriptions will receive a reimbursement.
Home Delivery Mail Order	• Members will need to contact their doctor to obtain a new prescription for a 90 day mail order supply.

***Pre-Approval (applies to Medical Plan)**

Pre-Approval is required for all In-Patient admissions and home health care. For elective admissions, call at least 7 days prior and emergency admissions call within 2 business days. A penalty of $500 or more will be imposed if you do not comply with the pre-approval requirements. This is in addition to the In-Patient Co-Pay. To complete the pre- approval, call customer service at 1-800-462-6615. Services related to mental health and alcohol/substance abuse will be referred to Excellus Behavioral Health Services, Inc. 1-800-649-6646.

Website: Medical and Prescription – www.bcbs.com or (800) 734-4069

Carrols Corporation
Health Insurance and Prescription Coverage
At A Glance

Blue Cross Blue Shield
HDHP – PLAN 3 for Team Members

Eligibility	• If you wish to participate in the medical plan, enrollment is required • Your Eligible Dependent Child(ren) may be covered under your plan up to age 26 • Coverage for Domestic Partners
Plan Design	• High Deductible Health Plans - A plan with a higher deductible and lower premiums • One identification card for both the medical plan and prescription plan
Employee Contribution Level	• **See Weekly Rate sheet located on the Home Page of your Benefits Communication Portal.** • **When electing your benefits on the Benefits Enrollment Portal your weekly deductions will be calculated for you in your cart summary on the right side of the screen.**
Health Plan In-Network Benefit	• Calendar year deductible – $5,500/Individual and $11,000/Family • Deductible does not apply to Preventive Care • 0% Co-insurance once deductible is met • $0.00 Co-pay once deductible is met
Health Plan Out-of-Network Benefit	• Calendar year deductible – $6,050/Individual and $12,100/Family • Deductible does not apply to Preventive Care • 0% Co-insurance once deductible is met • $0.00 Co-pay once deductible is met

Additional Health Plan Benefits	• You may enroll your adult child up to age 26 in your Medical plan regardless of their student status or marital status.
	• Some essential benefits which do not require a co-pay or co-insurance are:
	  • Well Child Visits up to Age 21
	  • Immunizations
	  For the full list of essential benefits, contact Blue Cross Blue Shield
	• If one person enrolled in two-person or family plan meets the Out of Pocket Maximum (per person) of $6,650, the Health Plan will pay 100% of covered services and claims for that individual for the remainder of the plan year.

TELEMEDICINE	• BCBS Partnered with MDLIVE • Access to U.S. Board Certified physicians 24/7/365 via telephone and videoconference • Alternative to seeking non-emergency medical care if your primary care physician is not available • Save time and money by using Telemedicine rather than the Emergency Room or Urgent Care center. • Doctors can diagnose your symptoms, prescribe medication and send the prescription to your nearest pharmacy. • Registration required • $40.00 co-pay required at time of initial call. Payment via a credit card or Health Savings Account payment card. • www.excellusbcbs.com/telemedicine or telephone 1-866-692-5045 **Common conditions treated** • **Allergies** • **Asthma** • **Bronchitis** • **Cold & Flu** • **Sinus infections** **……and more!**
PRESCRIPTION COVERAGE	• One identification card for your health insurance and prescriptions • Retail network pharmacies and mail-order option • Prescriptions are subject to the plan's deductible. • Integrated Rx with Preventative Rx • Drugs included on the Preventative Drug List are subject to co-payment. All other drugs are subject to the overall plan deductible. • Pay one (1) co-payment for each prescription for 30-day supply • Mail Order: pay up to two (2) co-payments for 90-day supply • Select Home Delivery – Maintenance medications filled via mail order
Prescription Co-payments	• Prescriptions are subject to the plan's deductible • Drugs included on the Preventative Drug List are subject to the following co-payments: • Retail pharmacy: Generic medications $5 co-pay, preferred $35 co-pay, or brand name $70 co-pay • Mail-order: Generic medications $10 co-pay, preferred $70 co-pay, or brand name $140 co-pay for a 90- day supply
Non-Network Pharmacy	Employee must pay for the prescription at the time of service directly to the pharmacy and submit a reimbursement claim directly to Blue Cross Blue Shield. Blue Cross Blue Shield may reimburse the drug cost at the network pharmacy level. Not all prescriptions will receive a reimbursement.
Home Delivery Mail Order	• Members will need to contact their doctor to obtain a new prescription for a 90 day mail order supply.

***Pre-Approval (applies to Medical Plan)**

Pre-Approval is required for all In-Patient admissions and home health care. For elective admissions, call at least 7 days prior and emergency admissions call within 2 business days. A penalty of $500 or more will be imposed if you do not comply with the pre-approval requirements. This is in addition to the In-Patient Co-Pay. To complete the pre-approval, call customer service at 1-800-462-6615. Services related to mental health and alcohol/substance abuse will be referred to Excellus Behavioral Health Services, Inc. 1-800-649-6646.

Website: Medical and Prescription – www.bcbs.com or (800) 734-4069

Carrols Corporation
Pre-Tax vs. Post-Tax
Employee Deductions
At A Glance

What is the difference between pre-tax deductions and post-tax deductions?

Every payroll deduction fits into one of two categories: pre-tax deductions or post-tax deductions. Some deductions are required by law to fall into one category while others are a matter of choice. Your Employee Benefit Deductions are a matter of choice. The below explanations of pre-tax vs. post-tax deductions will help you decide.

Pre-Tax Deductions

What does pre-tax mean?

A pre-tax deduction means you are deducting your insurance premiums from your weekly gross pay before Medicare, Federal and State taxes are calculated, meaning you will likely owe less taxes. Employee benefits deducted on a pre-tax basis from your paycheck may also result in higher take home pay. This is because you are paying tax on a smaller amount of money.

Pre-Tax Deductions Example:

Annual Earnings:	$35,000.00
Employee Benefits deducted pre-tax:	- $1,260.00
Annual Taxable Income:	$33,500.00*

*Your taxes are then calculated based on this amount.

Post-Tax Deductions

What does post-tax mean?

Insurance premiums are deducted from your weekly gross pay after all Federal, State and withholding taxes.

There is no taxable benefit to you when your employee benefits are deducted from your paycheck post tax.

Pre-Tax Deductions vs. Post-Tax Deductions Example

	WITH PRE- TAX DEDUCTIONS	WITHOUT PRE-TAX DEDUCTIONS
Annual Pay	$35,000	$35,000
Pre-tax Benefit Contributions	-$1,500	-$0
Taxable Income	=$33,500	=$35,000
Federal Income and Social Security Taxes	-$7,362	-$7,852
Post - Tax Benefit Contributions	-$0	-$1,500
Spendable Income	=$26,138	=$25,648
Melissa's Tax Savings	$490	$0

PREVENTIVE DRUG LIST

Revised 10/2021

This Preventive Drug List contains medications that are used for the prevention of or the recurrence of certain diseases. This list is based on the nature of the drug, not on individual circumstances for which the drug may be prescribed.

Your plan's formulary and tier status apply to the medications on this list. If your plan has a closed formulary benefit, drugs that are non-formulary would not be considered preventive (even if they are included on this list). Step therapy, prior authorization and quantity limits are also applicable and will be subject to review. This list does not apply to excluded drugs (non FDA-approved, medical foods, etc.) and only applies to non-formulary drugs if a formulary exception has been approved. When part of the benefit, the Generic Advantage Program may be applicable.

Some plans include diabetic drugs, equipment and supplies as part of the medical benefit and therefore a different cost share may apply, these items can be found under the Blood Glucose Regulators category which include:

- Anti-diabetic Agents
- Blood Glucose supplies
- Insulins

This list does not indicate coverage. To confirm coverage or receive a complete description of your pharmacy benefit (including information regarding tier placement and coverage requirements such as step therapy, prior authorization and quantity limits), call the Customer Care number on the back of your Member Card.

This list is periodically updated to ensure that the drugs listed meet the criteria for inclusion.

Drug

ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS

ALCOHOL DETERRENTS/ANTI-CRAVING

NALTREXONE HCL

OPIOID DEPENDENCE TREATMENTS

BUNAVAIL
BUPRENORPHINE HCL
BUPRENORPHINE-NALOXONE
LUCEMYRA
SUBOXONE
ZUBSOLV

OPIOID REVERSAL AGENTS

KLOXXADO
LIFEMS NALOXONE
NALOXONE HCL
NARCAN

ANTICONVULSANTS

SODIUM CHANNEL AGENTS

CARBAMAZEPINE
CARBAMAZEPINE ER
CARBATROL
EPITOL
TEGRETOL
TEGRETOL XR

Drug

ANTIDEPRESSANTS

ANTIDEPRESSANTS, OTHER

BUPROPION HCL
BUPROPION HCL SR
BUPROPION XL
EMSAM
FORFIVO XL
MIRTAZAPINE
NARDIL
PARNATE
PHENELZINE SULFATE
REMERON
TRANYLCYPROMINE SULFATE
WELLBUTRIN SR
WELLBUTRIN XL

Drug

SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE

CELEXA
CITALOPRAM HBR
DESVENLAFAXINE ER
DESVENLAFAXINE SUCCINATE ER
EFFEXOR XR
ESCITALOPRAM OXALATE
FETZIMA
FLUOXETINE DR
FLUOXETINE HCL
FLUVOXAMINE MALEATE
FLUVOXAMINE MALEATE ER
LEXAPRO
MAPROTILINE HCL
NEFAZODONE HCL
PAROXETINE CR
PAROXETINE ER
PAROXETINE HCL
PAROXETINE MESYLATE
PAXIL
PAXIL CR
PEXEVA
PRISTIQ
PROZAC
SERTRALINE HCL
TRAZODONE HCL
TRINTELLIX
VENLAFAXINE HCL
VENLAFAXINE HCL ER
VIIBRYD
ZOLOFT

TRICYCLICS

AMITRIPTYLINE HCL
AMOXAPINE
ANAFRANIL
CLOMIPRAMINE HCL
DESIPRAMINE HCL
DOXEPIN HCL
IMIPRAMINE HCL
IMIPRAMINE PAMOATE
NORPRAMIN
NORTRIPTYLINE HCL
PAMELOR
PROTRIPTYLINE HCL
SURMONTIL
TOFRANIL
TRIMIPRAMINE MALEATE

ANTIEMETICS

ANTIEMETICS, OTHER

COMPAZINE
COMPRO
PERPHENAZINE

Drug

PROCHLORPERAZINE
PROCHLORPERAZINE MALEATE

ANTIPSYCHOTICS

1ST GENERATION/ATYPICAL

LOXAPINE SUCCINATE
THIOTHIXENE

1ST GENERATION/TYPICAL

CHLORPROMAZINE HCL
FLUPHENAZINE HCL
HALOPERIDOL
THIORIDAZINE HCL
TRIFLUOPERAZINE HCL

2ND GENERATION/ATYPICAL

ABILIFY
ABILIFY MYCITE
ARIPIPRAZOLE
ARIPIPRAZOLE ODT
ASENAPINE MALEATE
CAPLYTA
FANAPT
GEODON
INVEGA
LATUDA
NUPLAZID
OLANZAPINE
OLANZAPINE ODT
PALIPERIDONE ER
QUETIAPINE FUMARATE
QUETIAPINE FUMARATE ER
REXULTI
RISPERDAL
RISPERIDONE
RISPERIDONE ODT
SAPHRIS
SECUADO
SEROQUEL
SEROQUEL XR
VRAYLAR
ZIPRASIDONE HCL
ZYPREXA
ZYPREXA ZYDIS

TREATMENT-RESISTANT

CLOZAPINE
CLOZAPINE ODT
CLOZARIL
FAZACLO

BIPOLAR AGENTS

MOOD STABILIZERS

EQUETRO
LITHIUM CARBONATE
LITHIUM CARBONATE ER

Drug

LITHOBID

BLOOD GLUCOSE REGULATORS (Diabetic cost share may apply)

ANTIDIABETIC AGENTS

ACARBOSE
ACTOPLUS MET
ACTOPLUS MET XR
ACTOS
ADLYXIN
ALOGLIPTIN
ALOGLIPTIN-METFORMIN
ALOGLIPTIN-PIOGLITAZONE
AMARYL
AVANDIA
BYDUREON
BYDUREON BCISE
BYDUREON PEN
BYETTA
CHLORPROPAMIDE
CYCLOSET
DM2
DUETACT
FARXIGA
FORTAMET
GLIMEPIRIDE
GLIPIZIDE
GLIPIZIDE ER
GLIPIZIDE XL
GLIPIZIDE-METFORMIN
GLUCOPHAGE
GLUCOPHAGE XR
GLUCOTROL
GLUCOTROL XL
GLUCOVANCE
GLUMETZA
GLYBURIDE
GLYBURIDE MICRONIZED
GLYBURIDE-METFORMIN HCL
GLYNASE
GLYSET
GLYXAMBI
INVOKAMET
INVOKAMET XR
INVOKANA
JANUMET
JANUMET XR
JANUVIA
JARDIANCE
JENTADUETO
JENTADUETO XR
KAZANO
KOMBIGLYZE XR
METFORMIN ER GASTRIC
METFORMIN ER OSMOTIC
METFORMIN HCL
METFORMIN HCL ER

Drug

MIGLITOL
NATEGLINIDE
NESINA
ONGLYZA
OSENI
OZEMPIC
PIOGLITAZONE HCL
PIOGLITAZONE-GLIMEPIRIDE
PIOGLITAZONE-METFORMIN
PRANDIN
PRECOSE
QTERN
REPAGLINIDE
REPAGLINIDE-METFORMIN HCL
RIOMET
RIOMET ER
RYBELSUS
SEGLUROMET
STARLIX
STEGLATRO
STEGLUJAN
SYMLINPEN 120
SYMLINPEN 60
SYNJARDY
SYNJARDY XR
TANZEUM
TRADJENTA
TRIJARDY XR
TRULICITY
VICTOZA 2-PAK
VICTOZA 3-PAK
XIGDUO XR

BLOOD GLUCOSE SUPPLIES

BLOOD GLUCOSE METER
BLOOD GLUCOSE TEST STRIP
BLOOD GLUCOSE CONTROL
DEXCOM RECEIVER
DEXCOM SENSOR KIT
DEXCOM TRANSMITTER KIT
FREESTYLE LIBRE & LIBRE 2 READER
FREESTYLE LIBRE & LIBRE 2 SENSOR
INSULIN SYRINGE LANCETS
LANCING DEVICE
PEN NEEDLES

INSULINS

ADMELOG
ADMELOG SOLOSTAR
AFREZZA
APIDRA
APIDRA SOLOSTAR
BASAGLAR KWIKPEN U-100
FIASP
FIASP FLEXTOUCH
FIASP PENFILL
HUMALOG
HUMALOG JUNIOR KWIKPEN
HUMALOG KWIKPEN U-100
HUMALOG KWIKPEN U-200
HUMALOG MIX 50-50
HUMALOG MIX 50-50 KWIKPEN
HUMALOG MIX 75-25

Drug

INSULINS

HUMALOG MIX 75-25 KWIKPEN
HUMULIN 70/30 KWIKPEN
HUMULIN 70-30
HUMULIN N
HUMULIN N KWIKPEN
HUMULIN R
HUMULIN R U-500
HUMULIN R U-500 KWIKPEN
INSULIN ASPART
INSULIN ASPART FLEXPEN
INSULIN ASPART PENFILL
INSULIN ASPART PROT MIX 70-30
INSULIN LISPRO
INSULIN LISPRO JUNIOR KWIKPEN
INSULIN LISPRO KWIKPEN U-100
INSULIN LISPRO PROTAMINE MIX
LANTUS
LANTUS SOLOSTAR
LEVEMIR
LEVEMIR FLEXTOUCH
LYUMJEV
LYUMJEV KWIKPEN U-100
LYUMJEV KWIKPEN U-200
NOVOLIN 70-30
NOVOLIN 70-30 FLEXPEN
NOVOLIN N
NOVOLIN N FLEXPEN
NOVOLIN R
NOVOLIN R FLEXPEN
NOVOLOG
NOVOLOG FLEXPEN
NOVOLOG MIX 70-30
NOVOLOG MIX 70-30 FLEXPEN
SEMGLEE
SEMGLEE PEN
SOLIQUA 100-33
TOUJEO MAX SOLOSTAR
TOUJEO SOLOSTAR
TRESIBA
TRESIBA FLEXTOUCH U-100
TRESIBA FLEXTOUCH U-200
XULTOPHY 100-3.6

Drug

BLOOD PRODUCTS/MODIFIERS/VOLUME EXPANDERS

ANTICOAGULANTS

COUMADIN
ELIQUIS
JANTOVEN
PRADAXA
SAVAYSA
WARFARIN SODIUM
XARELTO
ZONTIVITY

BLOOD FORMATION MODIFIERS

AGRYLIN
ANAGRELIDE HCL

PLATELET MODIFYING AGENTS

AGGRENOX
ASPIRIN-DIPYRIDAMOLE ER
ASPIRIN-OMEPRAZOLE
BRILINTA
CILOSTAZOL
CLOPIDOGREL
DIPYRIDAMOLE
DURLAZA
EFFIENT
PLAVIX
PRASUGREL HCL
YOSPRALA

CARDIOVASCULAR AGENTS

ALPHA-ADRENERGIC AGONISTS

CATAPRES
CATAPRES-TTS 1
CATAPRES-TTS 2
CATAPRES-TT3 3
CLONIDINE
CLONIDINE HCL
GUANFACINE HCL
METHYLDOPA

Drug

ALPHA-ADRENERGIC BLOCKING AGENTS

CARDURA
DOXAZOSIN MESYLATE
MINIPRESS
PRAZOSIN HCL
TERAZOSIN HCL

ANGIOTENSIN II RECEPTOR ANTAGONISTS

ATACAND
AVAPRO
BENICAR
CANDESARTAN CILEXETIL
COZAAR
DIOVAN
EDARBI
EPROSARTAN MESYLATE
IRBESARTAN
LOSARTAN POTASSIUM
MICARDIS
OLMESARTAN MEDOXOMIL
TELMISARTAN
VALSARTAN

ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS

ACCUPRIL
ALTACE
BENAZEPRIL HCL
CAPTOPRIL
ENALAPRIL MALEATE
EPANED
FOSINOPRIL SODIUM
LISINOPRIL
LOTENSIN
MOEXIPRIL HCL
PERINDOPRIL ERBUMINE
PRINIVIL
QBRELIS
QUINAPRIL HCL
RAMIPRIL
TRANDOLAPRIL
VASOTEC
ZESTRIL

ANTIARRHYTHMICS

AMIODARONE HCL
BETAPACE
BETAPACE AF
DISOPYRAMIDE PHOSPHATE

Drug

DOFETILIDE
FLECAINIDE ACETATE
MEXILETINE HCL
MULTAQ
NORPACE
NORPACE CR
PACERONE
PROPAFENONE HCL
PROPAFENONE HCL ER
QUINIDINE GLUCONATE
QUINIDINE SULFATE
RYTHMOL SR
SORINE
SOTALOL
SOTALOL AF
SOTYLIZE
TIKOSYN

BETA-ADRENERGIC BLOCKING AGENTS

ACEBUTOLOL HCL
ATENOLOL
BETAXOLOL HCL
BISOPROLOL FUMARATE
BYSTOLIC
CARVEDILOL
CARVEDILOL ER
COREG
COREG CR
CORGARD
INDERAL LA
INDERAL XL
INNOPRAN XL
KAPSPARGO SPRINKLE
LABETALOL HCL
LOPRESSOR
METOPROLOL SUCCINATE
METOPROLOL TARTRATE
NADOLOL
PINDOLOL
PROPRANOLOL HCL
PROPRANOLOL HCL ER
TENORMIN
TIMOLOL MALEATE
TOPROL XL

CALCIUM CHANNEL BLOCKING AGENTS

ADALAT CC
AFEDITAB CR
AMLODIPINE BESYLATE
CALAN
CALAN SR
CARDIZEM
CARDIZEM CD
CARDIZEM LA
CARTIA XT
CONJUPRI
DILTIAZEM 12HR ER

Drug

DILTIAZEM 24HR ER
DILTIAZEM 24HR ER (CD)
DILTIAZEM 24HR ER (LA)
DILTIAZEM 24HR ER (XR)
DILTIAZEM HCL
DILT-XR
FELODIPINE ER
ISRADIPINE
KATERZIA
MATZIM LA
NICARDIPINE HCL
NIFEDIPINE
NIFEDIPINE ER
NIMODIPINE
NISOLDIPINE
NORVASC
NYMALIZE
PROCARDIA
PROCARDIA XL
SULAR
TAZTIA XT
TIADYLT ER
TIAZAC
VERAPAMIL ER
VERAPAMIL ER PM
VERAPAMIL HCL
VERAPAMIL SR
VERELAN
VERELAN PM

CARDIOVASCULAR AGENTS, OTHER

ACCURETIC
ALDACTAZIDE
ALISKIREN
AMILORIDE-HYDROCHLOROTHIAZIDE
AMLODIPINE BESYLATE-BENAZEPRIL
AMLODIPINE-OLMESARTAN
AMLODIPINE-VALSARTAN
AMLODIPINE-VALSARTAN-HCTZ
ATACAND HCT
ATENOLOL-CHLORTHALIDONE
AVALIDE
AZOR
BENAZEPRIL-HYDROCHLOROTHIAZIDE
BENICAR HCT
BISOPROLOL-HYDROCHLOROTHIAZIDE
BYVALSON
CANDESARTAN-HYDROCHLOROTHIAZID
CAPTOPRIL-HYDROCHLOROTHIAZIDE
DIOVAN HCT
DUTOPROL
DYAZIDE
EDARBYCLOR
ENALAPRIL-HYDROCHLOROTHIAZIDE
ENTRESTO
EXFORGE
EXFORGE HCT

Drug

FOSINOPRIL-HYDROCHLOROTHIAZIDE
HYZAAR
IRBESARTAN-HYDROCHLOROTHIAZIDE
LISINOPRIL-HYDROCHLOROTHIAZIDE
LOPRESSOR HCT
LOSARTAN-HYDROCHLOROTHIAZIDE
LOTENSIN HCT
LOTREL
MAXZIDE
MAXZIDE-25 MG
METHYLDOPA-HYDROCHLOROTHIAZIDE
METOPROLOL SUCCINATE ER-HCTZ
METOPROLOL-HYDROCHLOROTHIAZIDE
MICARDIS HCT
NADOLOL-BENDROFLUMETHIAZIDE
NEXLETOL
OLMESARTAN-AMLODIPINE-HCTZ
OLMESARTAN-HYDROCHLOROTHIAZIDE
PRESTALIA
PROPRANOLOL-HYDROCHLOROTHIAZID
QUINAPRIL-HYDROCHLOROTHIAZIDE
SPIRONOLACTONE-HCTZ
TARKA
TEKTURNA
TEKTURNA HCT
TELMISARTAN-AMLODIPINE
TELMISARTAN-HYDROCHLOROTHIAZID
TENORETIC 100
TENORETIC 50
TRANDOLAPRIL-VERAPAMIL ER
TRIAMTERENE-HCTZ
TRIAMTERENE-HYDROCHLOROTHIAZID
TRIBENZOR
TWYNSTA
VALSARTAN-HYDROCHLOROTHIAZIDE
VASERETIC
VECAMYL
ZESTORETIC
ZIAC

DIURETICS, CARBONIC ANHYDRASE INHIBITORS

ACETAZOLAMIDE
ACETAZOLAMIDE ER

DIURETICS, LOOP

BUMETANIDE
DEMADEX
EDECRIN
ETHACRYNIC ACID
FUROSEMIDE
LASIX
TORSEMIDE

DIURETICS, POTASSIUM-SPARING

ALDACTONE
AMILORIDE HCL
CAROSPIR
DYRENIUM

Drug

EPLERENONE
INSPRA
SPIRONOLACTONE
TRIAMTERENE

DIURETICS, THIAZIDE

CHLOROTHIAZIDE
CHLORTHALIDONE
DIURIL
HYDROCHLOROTHIAZIDE
INDAPAMIDE
METHYCLOTHIAZIDE
METOLAZONE
MICROZIDE

DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES

ANTARA
FENOFIBRATE
FENOFIBRIC ACID
FENOGLIDE
GEMFIBROZIL
LIPOFEN
LOPID
TRICOR
TRIGLIDE
TRILIPIX

DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS

ALTOPREV
ATORVASTATIN CALCIUM
CRESTOR
EZALLOR SPRINKLE
FLOLIPID
FLUVASTATIN ER
FLUVASTATIN SODIUM
LESCOL
LESCOL XL
LIPITOR
LIVALO
LOVASTATIN
PRAVACHOL
PRAVASTATIN SODIUM
ROSUVASTATIN CALCIUM
ROSZET
SIMVASTATIN
ZOCOR
ZYPITAMAG

DYSLIPIDEMICS, OTHER

CHOLESTYRAMINE
CHOLESTYRAMINE LIGHT
COLESEVELAM HCL
COLESTID
COLESTIPOL HCL
EZETIMIBE
EZETIMIBE-SIMVASTATIN
ICOSAPENT ETHYL
JUXTAPID
LOVAZA

Drug

OMEGA-3 ACID ETHYL ESTERS
PRALUENT PEN
PREVALITE
QUESTRAN
QUESTRAN LIGHT
REPATHA PUSHTRONEX
REPATHA SURECLICK
REPATHA SYRINGE
VASCEPA
VYTORIN
WELCHOL
ZETIA

CENTRAL NERVOUS SYSTEM AGENTS

FIBROMYALGIA AGENTS

CYMBALTA
DRIZALMA SPRINKLE
DULOXETINE HCL

ELECTROLYTES/MINERALS/METALS/VITAMINS

VITAMINS

VITAFOL FE PLUS
WESTGEL DHA

GENITOURINARY AGENTS

GENITOURINARY AGENTS, OTHER

PHEXXI

HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFY

ESTROGENS

AFIRMELLE
ALTAVERA
ALYACEN
AMETHIA
AMETHIA LO
AMETHYST
ANNOVERA
APRI
ARANELLE
ASHLYNA
AUBRA
AUBRA EQ
AUROVELA
AUROVELA 24 FE
AUROVELA FE
AVIANE
AYUNA
AZURETTE
BALCOLTRA
BALZIVA
BEKYREE
BEYAZ
BLISOVI 24 FE
BLISOVI FE
BRIELLYN
CAMRESE
CAMRESE LO

Drug
CAZIANT
CHARLOTTE 24 FE
CHATEAL
CHATEAL EQ
CRYSELLE
CYCLAFEM
CYRED
CYRED EQ
DASETTA
DAYSEE
DESOGESTREL-ETHINYL ESTRADIOL
DESOGESTR-ETH ESTRAD ETH ESTRA
DROSPIRENONE-ETH ESTRA-LEVOMEF
DROSPIRENONE-ETHINYL ESTRADIOL
ECONTRA ONE-STEP
ELINEST
ELURYNG
EMOQUETTE
ENPRESSE
ENSKYCE
ESTARYLLA
ESTROSTEP FE
ETHYNODIOL-ETHINYL ESTRADIOL
ETONOGESTREL-ETHINYL ESTRADIOL
FALMINA
FAYOSIM
FEMYNOR
GEMMILY
GENERESS FE
GIANVI
HAILEY
HAILEY 24 FE
HAILEY FE
INTROVALE
ISIBLOOM
JAIMIESS
JASMIEL
JOLESSA
JULEBER
JUNEL
JUNEL FE
JUNEL FE 24
KAITLIB FE
KALLIGA
KARIVA
KELNOR 1-35
KELNOR 1-50
KIMIDESS
KURVELO
LARIN
LARIN 24 FE
LARIN FE
LARISSIA
LAYOLIS FE
LEENA
LESSINA

Drug
LEVONEST
LEVONORGESTREL-ETH ESTRADIOL
LEVONORG-ETH ESTRAD ETH ESTRAD
LEVORA-28
LILLOW
LO LOESTRIN FE
LOESTRIN
LOESTRIN FE
LOJAIMIESS
LORYNA
LOSEASONIQUE
LOW-OGESTREL
LO-ZUMANDIMINE
LUTERA
MARLISSA
MELODETTA 24 FE
MIBELAS 24 FE
MICROGESTIN
MICROGESTIN 24 FE
MICROGESTIN FE
MILI
MINASTRIN 24 FE
MIRCETTE
MONO-LINYAH
MONONESSA
MY CHOICE
MYZILRA
NATAZIA
NECON
NEW DAY
NEXTSTELLIS
NIKKI
NORETHINDRONE-E.ESTRADIOL-IRON
NORETHINDRON-ETHINYL ESTRADIOL
NORETHIN-ETH ESTRA-FERROUS FUM
NORGESTIMATE-ETHINYL ESTRADIOL
NORTREL
NUVARING
OCELLA
OGESTREL
ORSYTHIA
ORTHO TRI-CYCLEN
ORTHO TRI-CYCLEN LO
ORTHO-CYCLEN
PHILITH
PIMTREA
PIRMELLA
PORTIA
PREVIFEM
QUARTETTE
QUASENSE
RAJANI
RECLIPSEN
RIVELSA
SAFYRAL
SEASONIQUE
SETLAKIN

Drug

SIMLIYA
SIMPESSE
SPRINTEC
SRONYX
SYEDA
TARINA 24 FE
TARINA FE
TARINA FE 1-20 EQ
TAYTULLA
TILIA FE
TRI FEMYNOR
TRI-ESTARYLLA
TRI-LEGEST FE
TRI-LINYAH
TRI-LO-ESTARYLLA
TRI-LO-MARZIA
TRI-LO-MILI
TRI-LO-SPRINTEC
TRI-MILI
TRINESSA
TRINESSA LO
TRI-PREVIFEM
TRI-SPRINTEC
TRIVORA-28
TRI-VYLIBRA
TRI-VYLIBRA LO
TWIRLA
TYDEMY
VELIVET
VESTURA
VIENVA
VIORELE
VYFEMLA
VYLIBRA
WERA
WYMZYA FE
XULANE
YASMIN 28
YAZ
ZARAH
ZOVIA 1-35E
ZUMANDIMINE

PROGESTINS

CAMILA
DEBLITANE
DEPO-PROVERA
DEPO-SUBQ PROVERA 104
ERRIN
HEATHER
INCASSIA
JENCYCLA
JOLIVETTE
LYZA
NORA-BE
NORLYDA
ORTHO MICRONOR

Drug

SHAROBEL
SLYND
TULANA

SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS

EVISTA
RALOXIFENE HCL

IMMUNOLOGICAL AGENTS

IMMUNE SUPPRESSANTS

ASTAGRAF XL
AZASAN
AZATHIOPRINE
CELLCEPT
CYCLOSPORINE
CYCLOSPORINE MODIFIED
ENVARSUS XR
EVEROLIMUS
GENGRAF
IMURAN
MYCOPHENOLATE MOFETIL
MYCOPHENOLIC ACID
MYFORTIC
NEORAL
PROGRAF
RAPAMUNE
SANDIMMUNE
SIROLIMUS
TACROLIMUS
ZORTRESS

METABOLIC BONE DISEASE AGENTS

METABOLIC BONE DISEASE AGENTS

ACTONEL
ALENDRONATE SODIUM
ATELVIA
BINOSTO
BONIVA
ETIDRONATE DISODIUM
FORTEO
FOSAMAX
FOSAMAX PLUS D
IBANDRONATE SODIUM
RISEDRONATE SODIUM
RISEDRONATE SODIUM DR
TERIPARATIDE
TYMLOS

MISCELLANEOUS THERAPEUTIC AGENTS

MISCELLANEOUS THERAPEUTIC AGENTS

PEAK FLOW METER NEEDLE
PEAK FLOW METER W/INHALER ASSIST DEVICE

Drug

RESPIRATORY TRACT/PULMONARY AGENTS

ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS

ALVESCO
ARMONAIR DIGIHALER
ARNUITY ELLIPTA
ASMANEX
ASMANEX HFA
BUDESONIDE FLOVENT
DISKUS FLOVENT HFA
PULMICORT PULMICORT
FLEXHALER QVAR
REDIHALER

ANTILEUKOTRIENES

ACCOLATE
MONTELUKAST SODIUM
SINGULAIR
ZAFIRLUKAST
ZILEUTON ER
ZYFLO
ZYFLO CR

BRONCHODILATORS, ANTICHOLINERGIC

ATROVENT HFA
INCRUSE ELLIPTA
IPRATROPIUM BROMIDE
LONHALA MAGNAIR REFILL
LONHALA MAGNAIR STARTER
SEEBRI NEOHALER
SPIRIVA
SPIRIVA RESPIMAT
TUDORZA PRESSAIR
YUPELRI

BRONCHODILATORS, SYMPATHOMIMETIC

ARCAPTA NEOHALER
PERFOROMIST
SEREVENT DISKUS
STRIVERDI RESPIMAT

PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE

DALIRESP

Drug

RESPIRATORY TRACT AGENTS, OTHER

ADVAIR DISKUS
ADVAIR HFA
AIRDUO DIGIHALER
AIRDUO RESPICLICK
ANORO ELLIPTA
BEVESPI AEROSPHERE
BREO ELLIPTA
BUDESONIDE-FORMOTEROL FUMARATE
COMBIVENT RESPIMAT
DUAKLIR PRESSAIR
DULERA
FLUTICASONE-SALMETEROL
IPRATROPIUM-ALBUTEROL
STIOLTO RESPIMAT
SYMBICORT
TRELEGY ELLIPTA
UTIBRON NEOHALER
WIXELA INHUB

Excellus

CARROLS CORPORATION

Benefit Comparison

Benefit Time Period 01/01/2022 - 12/31/2022

Cost Sharing Expenses

Benefit Name	PPO Plan 1 In-Network	PPO Plan 1 Out-of-Network	PPO Plan 1 Limits	HDHP Plan 2 In-Network	HDHP Plan 2 Out-of-Network	HDHP Plan 2 Limits	HDHP Plan 3 In-Network	HDHP Plan 3 Out-of-Network	HDHP Plan 3 Limits
Deductible - Single	$0	$250		$2,600	$5,200		$5,500	$6,050	
Deductible - Family	$0	$750		$5,200	$10,400		$11,000	$12,100	
Coinsurance	20%	30%		20%	40%		0%	0%	
Annual Out of Pocket Maximum - Single	$3,000	$4,000		$4,000	$8,000		$5,500	$6,050	
Annual Out of Pocket Maximum - Family	$9,000	$12,000		$8,000	$16,000		$11,000	$12,100	

Office Visits

Benefit Name	PPO Plan 1 In-Network	PPO Plan 1 Out-of-Network	PPO Plan 1 Limits	HDHP Plan 2 In-Network	HDHP Plan 2 Out-of-Network	HDHP Plan 2 Limits	HDHP Plan 3 In-Network	HDHP Plan 3 Out-of-Network	HDHP Plan 3 Limits
Primary Care	$25 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Specialist	$35 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Annual Well Visit	covered in full	covered in full		covered in full	covered in full		covered in full	covered in full	

Plan Limits

Benefit Name	PPO Plan 1 In-Network	PPO Plan 1 Out-of-Network	PPO Plan 1 Limits	HDHP Plan 2 In-Network	HDHP Plan 2 Out-of-Network	HDHP Plan 2 Limits	HDHP Plan 3 In-Network	HDHP Plan 3 Out-of-Network	HDHP Plan 3 Limits
Plan/Calendar Year			Calendar year benefits			Calendar year benefits			Calendar year benefits
Eligible for HSA			No			Yes			Yes
Eligible for FSA			Yes			No			No

	PPO Plan 1			HDHP Plan 2			HDHP Plan 3		
Who is Covered									
Benefit Name	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**
Domestic Partner Coverage			Yes			Yes			Yes
Inpatient Facility									
Benefit Name	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**
Inpatient Hospital Services	$450 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Mental Health Care	$450 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Substance Use Detoxification	$450 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Skilled Nursing Facility	$450 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Days per Year	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Days per Year
Physical Rehabilitation	Not Covered	Not Covered	Not Covered	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	60 Days per Year	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	60 Days per Year
Maternity Care	$450 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Inpatient Professional Services									
Benefit Name	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**
Inpatient Hospital Surgery	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Anesthesia	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

	PPO Plan 1			HDHP Plan 2			HDHP Plan 3		
Outpatient Facility Services									
Benefit Name	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**
Diagnostic X-ray	20% Coinsurance	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	20% Coinsurance	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Home Care Benefit	Inclusive of Home Care Benefit		Inclusive of Home Care Benefit	Inclusive of Home Care Benefit		Inclusive of Home Care Benefit	Inclusive of Home Care Benefit	
Dialysis	20% Coinsurance	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Mental Health Care	$25 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Substance Use Care	$25 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Home Care									
Benefit Name	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**
Home Care	20% Coinsurance	25% Coinsurance Subject to $50 Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Hospice Care									
Benefit Name	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**
Hospice Care	20% Coinsurance	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

Professional Services

Benefit Name	PPO Plan 1 In-Network	PPO Plan 1 Out-of-Network	PPO Plan 1 Limits	HDHP Plan 2 In-Network	HDHP Plan 2 Out-of-Network	HDHP Plan 2 Limits	HDHP Plan 3 In-Network	HDHP Plan 3 Out-of-Network	HDHP Plan 3 Limits
Diagnostic X-ray	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Diagnostic X-ray and Pathology	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Infusion Therapy	PCP/Specialist - Inclusive of Home Care Benefit	Inclusive of Home Care Benefit		PCP/Specialist - Inclusive of Home Care Benefit	Inclusive of Home Care Benefit		PCP/Specialist - Inclusive of Home Care Benefit	Inclusive of Home Care Benefit	
Dialysis	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Mental Health Care	PCP/Specialist - $25 Copayment	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Maternity Care	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Chiropractic Care	PCP/Specialist - $25 Copayment	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Allergy Testing	Specialist - $35 Copayment PCP - $25 Copayment	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Hearing Evaluation Routine	PCP/Specialist - Not Covered	Not Covered		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	1 Exam per Year	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	1 Exam per Year

Outpatient Facility

Benefit Name	PPO Plan 1 In-Network	PPO Plan 1 Out-of-Network	PPO Plan 1 Limits	HDHP Plan 2 In-Network	HDHP Plan 2 Out-of-Network	HDHP Plan 2 Limits	HDHP Plan 3 In-Network	HDHP Plan 3 Out-of-Network	HDHP Plan 3 Limits
Physical Rehabilitation	$35 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	$35 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	$35 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year	0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per year

Outpatient Professional Services

Benefit Name	In-Network	Out-of-Network	Limits	In-Network	Out-of-Network	Limits	In-Network	Out-of-Network	Limits
Physical Rehabilitation	PCP/Specialist - $35 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	PCP/Specialist - $35 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year	PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP/Specialist - $35 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year	PCP/Specialist - 0% Coinsurance Subject to Deductible	Inclusive of Home Care Benefit	45 Visits per year

Outpatient Facility and Professional Provider

Benefit Name	In-Network	Out-of-Network	Limits	In-Network	Out-of-Network	Limits	In-Network	Out-of-Network	Limits
Adult Physical Examination	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 exam per year	PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 exam per year	PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	1 exam per year
Adult Immunizations	PCP/Specialist - Covered in Full	Not Covered		PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Well Child Visits and Immunizations	PCP/Specialist - Covered in Full	Covered in Full		PCP/Specialist - Covered in Full	Covered in Full		PCP/Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Cervical Cytology Preventative	Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	0% Coinsurance Subject to Deductible	
Prostrate Cancer Screenings	Specialist - $35 Copayment PCP - $25 copayment	30% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	

	PPO Plan 1			HDHP Plan 2			HDHP Plan 3		
Mammography Preventative Facility	Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	0% Coinsurance Subject to Deductible	
Mammography Preventative Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Bone Density Testing Facility	$35 Copayment	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Bone Density Testing Professional	Specialist - $35 Copayment PCP - $25 copayment	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible		Covered in Full	0% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP/Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP/Specialist - Covered in Full	40% Coinsurance Subject to Deductible		PCP/Specialist - Covered in Full	0% Coinsurance Subject to Deductible	

Additional Benefits

Benefit Name	In-Network	Out-of-Network	Limits	In-Network	Out-of-Network	Limits	In-Network	Out-of-Network	Limits
Treatment of Diabetes Insulin and Supplies	PCP/Specialist - $15 Copayment	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP/Specialist - $15 Copayment	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Medical Supplies	PCP/Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible		PCP/Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		PCP/Specialist - 0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Acupuncture	PCP/Specialist - Not Covered	Not Covered		PCP/Specialist - Not Covered	Not Covered		PCP/Specialist - Not Covered	Not Covered	
Private Duty Nursing	PCP/Specialist - Not Covered	Not Covered		PCP/Specialist - Not Covered	Not Covered		PCP/Specialist - Not Covered	Not Covered	

	PPO Plan 1			HDHP Plan 2			HDHP Plan 3		
ER Facility									
Benefit Name	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**
OP Facility Emergency Room Visit	$400 Copayment	$400 Copayment		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Transportation									
Benefit Name	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**
Prehospital Emergency Services Transportation	Covered in Full	Covered in Full		20% Coinsurance Subject to Deductible	20% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Telemedicine									
Benefit Name	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**
Telemedicine Telephone or Video Consultation	$10 Copayment	Not covered		$40 Copayment	Not covered		$40 Copayment	Not covered	
Urgent Care Facility									
Benefit Name	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**
Urgent Care Center Facility Visit	$75 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible		0% Coinsurance Subject to Deductible	0% Coinsurance Subject to Deductible	
Vision									
Benefit Name	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**	**In-Network**	**Out-of-Network**	**Limits**
Adult Eye Exams - Routine	Not Covered	Not Covered		Not Covered	Not Covered		Not Covered	Not Covered	
Adult Eyewear - Routine	Not Covered	Not Covered		Not Covered	Not Covered		Not Covered	Not Covered	
Pediatric Eye Exams - Routine	Not Covered	Not Covered		Not Covered	Not Covered		Not Covered	Not Covered	
Pediatric Eyewear - Routine	Not Covered	Not Covered		Not Covered	Not Covered		Not Covered	Not Covered	

Prescription Drug Coverage

Benefit Name	PPO Plan 1 In-Network	PPO Plan 1 Out-of-Network	PPO Plan 1 Limits	HDHP Plan 2 In-Network	HDHP Plan 2 Out-of-Network	HDHP Plan 2 Limits	HDHP Plan 3 In-Network	HDHP Plan 3 Out-of-Network	HDHP Plan 3 Limits
Generic Drugs (Retail)	$20 Copayment (30 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply	After 2 refills of a maintenance medication from a retail location, member may either select Mail Order or pay an additional 20% co-pay fee.	Subject to the deductible. If drug is on Preventative List: $5 Copayment (30 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply		Subject to the deductible. If drug is on Preventative List: $5 Copayment (30 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply	
Generic Drugs (Mail Order)	$35 Copayment (90 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply		Subject to the deductible. If drug is on Preventative List: $10 Copayment (90 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply		Subject to the deductible. If drug is on Preventative List: $10 Copayment (90 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply	
Preferred Brand Drugs (Retail)	$45 Copayment (30 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply	After 2 refills of a maintenance medication from a retail location, member may either select Mail Order or pay an additional 20% co-pay fee.	Subject to the deductible. If drug is on Preventative List: $35 Copayment (30 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply		Subject to the deductible. If drug is on Preventative List: $35 Copayment (30 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply	
Preferred Brand Drugs (Mail Order)	$90 Copayment (90 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply		Subject to the deductible. If drug is on Preventative List: $70 Copayment (90 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply		Subject to the deductible. If drug is on Preventative List: $70 Copayment (90 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply	
Non-preferred Brand Drugs (Retail)	$55 Copayment (30 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply	After 2 refills of a maintenance medication from a retail location, member may either select Mail Order or pay an additional 20% co-pay fee.	Subject to the deductible. If drug is on Preventative List: $70 Copayment (30 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply		Subject to the deductible. If drug is on Preventative List: $70 Copayment (30 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply	
Non-preferred Brand Drugs (Mail Order)	$110 Copayment (90 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply		Subject to the deductible. If drug is on Preventative List: $140 Copayment (90 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply		Subject to the deductible. If drug is on Preventative List: $140 Copayment (90 day supply)	Employee must pay for the prescription at the time of service and may submit a claim to BCBS for reimbursement. *Restrictions may apply	

***This information is being provided to you as required by the United States Department of Labor.**

Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins every October for coverage starting as early as January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.*

> Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage-is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information:

For more information about your coverage offered by your employer, please check your summary plan description or contact the Carrols Corporation Employee Benefits Department at 1-800-348-1074.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Carrols Restaurant Group, Inc. - 968 James Street - Syracuse, NY 13203 - 1-800-348-1074 - Fax: 315-479-8018

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of October 15, 2021. Contact your State for more information on eligibility –

ALABAMA Medicaid	CALIFORNIA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA Medicaid	**COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS Medicaid	**FLORIDA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE Medicaid

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa

Phone: 1-800-862-4840

MINNESOTA Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY Medicaid and CHIP	SOUTH DAKOTA Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK Medicaid	**TEXAS Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA Medicaid	**UTAH Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA Medicaid	**VERMONT Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA Medicaid and CHIP	**VIRGINIA Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON Medicaid	**WASHINGTON Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA Medicaid	**WEST VIRGINIA Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND Medicaid and CHIP	**WISCONSIN Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA Medicaid	**WYOMING Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since October 15, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply.

If you would like more information on WHCRA benefits, you may contact Blue Cross and Blue Shield of CNY at 1-800-734-4069 or the Employee Benefits Department at 1-800-348-1074 extension 2204, 2558, 2243 or 2325.

October 2021
OMB 0938-0990

Creditable Coverage: Your Prescription Drug Coverage and Medicare

If you or any of your dependents are Medicare eligible, or will become Medicare eligible in 2021 or 2022, read this notice carefully. Also, be sure to provide a copy of this notice to any of your Medicare eligible dependents covered under the Carrols Restaurant Group, Inc. group health plan.

If you or your covered dependents ***are not*** eligible for Medicare, no action is required on your part.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Carrols Restaurant Group, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Carrols Restaurant Group, Inc. has determined that the prescription drug coverage offered by the Carrols Corporation Healthcare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. If you decide to join a Medicare drug plan, your current Carrols Restaurant Group, Inc coverage will be affected.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Carrols Restaurant Group, Inc coverage will be affected. If you do decide to join a Medicare drug plan and drop your current Carrols Restaurant Group, Inc coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Carrols Restaurant Group, Inc and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information or call Kelly Dickter, Corporate Human Resources Director, 1-800-348-1074 extension 2392.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Carrols Restaurant Group, Inc changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Contact--Position/Office: Michelle Buonocore, Employee Benefits Manager
Address: 968 James Street, Syracuse, NY 13203
Phone Number: 1-800-348-1074 extension 2325

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?	Out-of-Network: $250 Individual/$500 Two Person/$750 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: $3,000 Individual/$6,000 Two Person/$9,000 Family; Out-of-Network: $4,000 Individual/$8,000 Two Person/ $12,000 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, 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 penalties for failure to obtain preauthorization for services, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.excellusbcbs.com or call 1-800-499-1275 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay/visit	30% Coinsurance	None
	Specialist visit	$35 Copay/visit	30% Coinsurance	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge	Adult Physical: 30% Coinsurance Adult Immunizations: Not Covered 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 combined in and out of network
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: 20% Coinsurance Blood Work: 20% Coinsurance	X-Ray: 30% Coinsurance Blood Work: 30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	30% Coinsurance	Preauthorization Required. If you don't get a preauthorization, benefits will be reduced by 50% of Coinsurance up to $500.
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)	$20/prescription retail, $35/ prescription mail order	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 of the drug. Specialty drugs must be filled by a Designated Pharmacy. Specialty drugs are not eligible for mail order.
	Tier 2 (Preferred brand drugs)	$45/prescription retail, $90/ prescription mail order	Not Covered	
	Tier 3 (Non-preferred brand drugs)	$55/prescription retail, $110/prescription mail	Not Covered	
	Specialty drugs	$55/prescription retail	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	30% Coinsurance	None
	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	
If you need immediate medical attention	Emergency room care	$400 Copay/visit	$400 Copay/visit	None
	Emergency medical transportation	No Charge	No Charge Deductible does not apply	None
	Urgent care	$75 Copay/visit	30% Coinsurance	None

* 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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$450 Copay	30% Coinsurance	Preauthorization Required for out-of-network services only. If you don't get a preauthorization, benefits will be reduced by 50% of Coinsurance up to $500. However, Preauthorization is Not Required for Emergency Admissions
	Physician/surgeon fees	20% Coinsurance	30% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay/visit	30% Coinsurance	None
	Inpatient services	$450 Copay	30% Coinsurance	
If you are pregnant	Office visits	No Charge	30% Coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% Coinsurance	30% 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	$450 Copay	30% Coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	25% Coinsurance	Deductible is limited to $50 Out-of-Network Preauthorization Required. If you don't get a preauthorization, benefits will be reduced by 50% of Coinsurance up to $500.
	Rehabilitation services	$35 Copay/visit	30% Coinsurance	None
	Habilitation services	$35 Copay/visit	30% Coinsurance	
	Skilled nursing care	$450 Copay	30% Coinsurance	Preauthorization Required Out-of-Network services only. If you don't get a preauthorization, benefits will be reduced by 50% of Coinsurance up to $500.
	Durable medical equipment	20% Coinsurance	30% Coinsurance	None
	Hospice services	20% Coinsurance	30% Coinsurance	Family bereavement counseling limited to 5 Visits per 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	

* 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)	
	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 www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the phone number on Your ID card or www.excellusbcbs.com; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; 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: www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

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

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

About these Coverage Examples:

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

Peg is Having a Baby

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

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$450
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	**$12,820**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$470
Coinsurance	$690
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,220**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$450
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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,290
Coinsurance	$30
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,380**

Mia's Simple Fracture

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

The plan's overall deductible	$0
Specialist copayment	$35
Hospital (facility) copayment	$450
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	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$540
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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

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 sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

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: $2,600 Individual/ $5,200 Family; Out-of-Network: $5,200 Individual/ $10,400 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: $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, 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	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 plan 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	Generic drugs	$5/prescription retail, $10/ prescription mail order	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 of the drug. Specialty drugs must be filled by a Designated Pharmacy. Specialty drugs are not eligible for mail order.
	Brand drugs	$35/prescription retail, $70/ prescription mail order	Not Covered	
	Specialty drugs	$70/prescription retail	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	40% 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	

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 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.
	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

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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 www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

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

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About these Coverage Examples:

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Peg is Having a Baby

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

The plan's overall deductible	**$2,600**
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	**$12,820**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,600
Copayments	$0
Coinsurance	$1,400
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	**$2,600**
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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,600
Copayments	$70
Coinsurance	$870
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,600**

Mia's Simple Fracture

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

The plan's overall deductible	**$2,600**
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	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,930
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,930**

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

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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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

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: $5,500 Individual/ $11,000 Family; Out-of-Network: $6,050 Individual/ $12,100 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: $5,500 Individual/$11,000 Family; Out-of-Network: $6,050 Individual/ $12,100 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	No Charge	No Charge	None
	Specialist visit	No Charge	No Charge	
	Preventive care/screening/ immunization	Adult Physical: No Charge Adult Immunizations: No Charge Well Child Visit: No Charge Deductible does not apply	Adult Physical: No Charge Adult Immunizations: No Charge 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 plan year
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: No Charge Blood Work: No Charge	X-Ray: No Charge Blood Work: No Charge	None
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.excellusbcbs.com/rxlist	Generic drugs	$5/prescription retail, $10/ prescription mail order	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 of the drug. Specialty drugs must be filled by a Designated Pharmacy. Specialty drugs are not eligible for mail order.
	Brand drugs	$35/prescription retail, $70/ prescription mail order	Not Covered	
	Specialty drugs	$70/prescription retail	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	
If you need immediate medical attention	Emergency room care	No Charge	No Charge	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	No Charge	No Charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	None
	Physician/surgeon fees	No Charge	No Charge	

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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 need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	No Charge	None
	Inpatient services	No Charge	No Charge	
If you are pregnant	Office visits	No Charge	No Charge	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge	No Charge	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	No Charge	No Charge	None
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	None
	Rehabilitation services	No Charge	No Charge	45 Visits per plan year limit
	Habilitation services	No Charge	No Charge	45 Visits per plan year limit
	Skilled nursing care	No Charge	No Charge	45 Days per plan year limit
	Durable medical equipment	No Charge	No Charge	None
	Hospice services	No Charge	No Charge	Family bereavement counseling limited to 5 Visits per plan year
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	Children's glasses	Not Covered	Not Covered	
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(9 months of in-network pre-natal care and a hospital delivery)

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Coinsurance	**0%**
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Specialist office visits (*prenatal care*)
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In this example, Peg would pay:

Cost Sharing	
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What isn't covered	
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The total Peg would pay is	**$5,560**

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

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

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Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,970**

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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.

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