




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 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.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (844) 235-4455 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$0</b> /single or <b>\$0</b> /family for In- <a href="#">Network Providers</a> . <b>\$500</b> /single or <b>\$1,250</b> /family for Out-of- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, in-network services are not subject to a deductible	You will have to meet the out of network <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	Yes. Out of network services require deductible, in addition to a <b>\$50</b> per person per calendar year for In-Network Retail Prescription Drugs. Deductible does not apply to Tier 1 Generic drugs	You will have to meet a drug deductible before copays apply. The prescription drug deductible does not apply to maintenance medications obtained through a participating mail order pharmacy.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$5,080</b> /single or <b>\$12,700</b> /family for In- <a href="#">Network Providers</a> . <b>\$1,400</b> /single or <b>\$3,500</b> /family for Out-of- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, Blue Card PPO.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a>

		for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30/visit	Deductible / coinsurance	-----none-----
	<a href="#">Specialist</a> visit	\$30/visit	Deductible / coinsurance	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	\$0/visit	Deductible / coinsurance	Annual Physical Exam: Not covered for Out-of- <a href="#">Network Providers</a> . You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$30 copay for examinations and evaluations; 10% coinsurance for other services	Deductible / coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	\$30 copay for examinations and evaluations; 10% coinsurance for other services	Deductible / coinsurance	Penalties applied if precertification is not obtained

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at www.[insert].	Tier 1 - Typically Generic	\$10/prescription (Retail and Mail Order)	Not Covered	\$50 per person per calendar year for In-Network Retail Prescription Drugs. Deductible does not apply to Tier 1 Generic drugs
	Tier 2 - Typically <a href="#">Preferred</a> / Brand	\$20/prescription (Retail and Mail Order)		Retail – 1 copay required for up to a 30-day supply
	Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a>	\$40/prescription (Retail and Mail Order)		Mail Order has the same copayments as retail, but only two copayments are required for a 90-day supply. If you are taking a Maintenance Medication, you are required to use the designated mail order service through our Pharmacy Benefits Manager.
				\$50 deductible does not apply to maintenance drugs obtained in a retail setting through the AMMO participating pharmacy.  Prior Authorization may be required
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$30/visit	Deductible / coinsurance	-----none-----
	Physician/surgeon fees	\$30 copay for examinations and evaluations; 10% coinsurance for other services	Deductible / coinsurance	Penalties applied if precertification is not obtained.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$50/visit	Covered as In- <a href="#">Network</a>	Copay waived if admitted within 24 hours.
	<a href="#">Emergency medical transportation</a>	10% coinsurance	Covered as In- <a href="#">Network</a>	Air Ambulance covered In- <a href="#">Network</a> only.
	<a href="#">Urgent care</a>	\$30/visit	Covered as In- <a href="#">Network</a>	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance	Deductible / coinsurance	Penalties applied if precertification is not obtained.
	Physician/surgeon fees	10% coinsurance	Deductible / coinsurance	Penalties applied if precertification is not obtained.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office: \$30 copay for examinations and evaluations; 10% coinsurance for other services  Facility: 10% coinsurance	Deductible / coinsurance	Penalties applied if precertification is not obtained
	Inpatient services	10% coinsurance	Deductible / coinsurance	Penalties applied if precertification is not obtained.
<b>If you are pregnant</b>	Office visits	\$30 copay for first visit; 10% coinsurance for all other visits and services	Deductible / coinsurance	Penalties applied if precertification is not obtained
	Childbirth/delivery professional services	10% coinsurance	Deductible / coinsurance	
	Childbirth/delivery facility services	10% coinsurance	Deductible / coinsurance	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% coinsurance	30% <a href="#">coinsurance deductible</a> does not apply	Limited to 365 visits per calendar year.
	<a href="#">Rehabilitation services</a>	\$30 copay for examinations and evaluations; 10% coinsurance for other services	Not covered	Penalties applied if precertification is not obtained.  Physical Therapy—unlimited visits per calendar year combined in home, office or outpatient facility.
	<a href="#">Habilitation services</a>	\$30 copay for examinations and evaluations; 10% coinsurance for other services		Occupational and Speech Therapy—limited to 30 visits per calendar year combined in home, office or outpatient facility.  Vision Therapy—unlimited visits per calendar year  All rehabilitation and habilitation visits count toward your rehabilitation visit limit
	<a href="#">Skilled nursing care</a>	10% coinsurance	Not covered	Limited to 365 days per calendar year.

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)	
	<a href="#">Durable medical equipment</a>	10% coinsurance	Not covered	Penalties applied if precertification is not obtained.
	<a href="#">Hospice services</a>	10% coinsurance	Not covered	210 days limit/lifetime for In- <a href="#">Network Providers</a> .
<b>If your child needs dental or eye care</b>	Children's eye exam	\$5 copay	\$30 allowance	Once every 24 months
	Children's glasses	Allowance/copay (see limitations & exceptions for detail)	\$64 frame allowance \$25-\$45 eyeglass lense allowance \$75 contact lense allowance	Frames: \$115 allowance then 20% off remaining balance Eyeglass Lenses: \$10 copay Contact Lenses: \$75 allowance then 15% off remaining balance
	Children's dental check-up	Not covered	Not covered	-----none-----

## Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

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

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Infertility Treatment
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

**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, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

ATTN: [Grievances](#) and [Appeals](#), P.O. Box 1407, Church Street Station, New York, NY 10008-1407

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

**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.*—————

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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	\$12,840
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$96
<b>The total Peg would pay is</b>	<b>\$136</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

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
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$6,041
<b>The total Joe would pay is</b>	<b>\$6,241</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,010
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$290
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$290</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (844) 235-4455

**Amharic** (በሌላ ቅጽ) ለበጎ ገንዘብ በደንበኞች ለማግኘት ወይም ለሌሎች ጉዳዮች ለመጠየቅ፣ ባለጊዜያዊ ጥያቄዎችን ለመቀራረፍ፣ ወይም ለሌሎች ጉዳዮች ለማግኘት፣ በደንበኞች ለማግኘት ወይም ለሌሎች ጉዳዮች ለመጠየቅ፣ (844) 235-4455 ይጠቀሙ።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 235-4455.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով` (844) 235-4455:

**Bassa (Bàsǎ́ Wùdù):** M̄ d̄yi d̄yi-diè-d̄è b̄é b̄édé b̄á céè-d̄è n̄ià k̄e dyí ní, ɔ m̄ò n̄i d̄yí-b̄èd̄è-in-d̄è b̄é m̄ k̄é gbo-kpá-kpá k̄è b̄ǎ́ kp̄ǎ́ d̄é m̄ bíd̄í-wùdùún b̄ó p̄idyí. B̄é m̄ k̄é wuđ-u-zìin-nyò d̄ò gbo wùdù k̄e, d̄á (844) 235-4455.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (844) 235-4455 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (844) 235-4455 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (844) 235-4455。

**Dinka (Dinka):** Na n̄oŋ thiëc n̄e ke de yā thore, ke yin n̄oŋ loŋ b̄e yi kuony ku w̄er al̄eu b̄e ḡēr yic yin ne thoŋ du ke cin w̄eu tāaūe ke piny. Te k̄or yin ba jam w̄en̄e ran ye thok geryic, ke yin c̄ol (844) 235-4455.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (844) 235-4455.

**Farsi (فارسي):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 235-4455 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 235-4455.



## Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (844) 235-4455.

**Greek (Ελληνικά):** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (844) 235-4455.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (844) 235-4455.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprete, rele (844) 235-4455.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (844) 235-4455 ।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (844) 235-4455.

**Igbo (Igbo):** Ọ bụr ụ na ị nwere ajujụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (844) 235-4455.

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (844) 235-4455.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (844) 235-4455.

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## Language Access Services:

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ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (844) 235-4455 ។

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**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລຳບວກວ່າມແບພາສາ, ໃຫ້ໂທຫາ (844) 235-4455.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjĩ bee nił hodoonih t'áadoo báąh ilinígóó.  
Ata' halne'ígíí la' bich'i' hadeesdzih nínízingo kojĩ' hodiilnih (844) 235-4455.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (844) 235-4455

**Oromo (Oromifaa):** Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 235-4455 bilbilla.

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