



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, visit www.cfablue.com or call 866-871-0839. 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 or call 866-871-0839 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$500 individual / \$1,000 family for in-network providers. Prescription drug plan expenses, non-covered services, charges in excess of the allowed benefit, pre-certification penalties, and balance-billed charges don't count toward the deductible.	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 out-of-network deductible until the total amount of out-of-network deductible expenses paid by all family members meets the overall out-of-network family deductible .
Are there services covered before you meet your deductible?	Yes. All in-network benefits and prescription drug benefits and are covered before you meet your deductible . Out-of-network emergency room care and air ambulance transportation are also covered before you meet your deductible .	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?	Yes. \$75 individual / \$150 family for prescription drug coverage.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	\$7,000 individual / \$14,000 family for in-network providers.	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?	Prescription drug plan expenses, pre-certification penalties, premiums, balance-billed charges, charges in excess of the allowed benefit, 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.cfablue.com or call 1-866-871-0839 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).

Important Questions	Answers	Why This Matters:
		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 .

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	\$35/visit*	Not covered	Primary care includes physicians in general practice, family practice, internal medicine, pediatrics, obstetrics/gynecology, or geriatrics; and nurse practitioners.
	Specialist visit	\$55/visit*	Not covered	—————none—————
	Preventive care/screening/immunization	No charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work, ultrasounds, etc.)	Physician Office visit copay \$35 PCP*/ \$55 Specialist*; No charge* for Outpatient Hospital Facility; \$20/visit* for Independent Facility	Not covered	—————none—————
	Imaging (CT/PET scans, MRIs)	Physician Office visit copay \$35 PCP*/ \$55 Specialist*; \$55/visit* for Outpatient Hospital Facility;	Not covered	Pre-certification required in order to avoid denial of the claim.
If you need drugs to treat your illness or condition	Generic drugs	\$25/prescription* (retail), \$50/prescription* (mail order)	Applicable copayment, plus charges in excess of the allowed amount	Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred brand drugs	20% coinsurance* to a maximum of \$75/prescription (retail),	Applicable copayment, plus charges in excess of the allowed amount	

For more information about limitations and exceptions, see plan or policy document at MyNIAMBenefits.com or call 866-871-0839

* After [deductible](#)

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)	
More information about prescription drug coverage is available at www.caremark.com .		\$150/prescription (mail order)		When received at an in-network pharmacy, no charge for over-the-counter drugs related to preventive care, or FDA-approved generic and over-the-counter contraceptive methods for women (prescription required). Prescription Drug Deductible: \$75 individual / \$150 family Prescription Drug Out-of-Pocket Maximum: \$1,900 individual / \$3,800 family
	Non-preferred brand drugs	30% coinsurance* to a maximum of \$125/prescription (retail), \$225/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	
	Specialty drugs	25% coinsurance* to a maximum of \$250/prescription	Applicable copayment, plus charges in excess of the allowed amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$55/visit* for ambulatory surgical facility \$200/visit* for outpatient hospital	Not covered	Pre-certification required in order to avoid denial of the claim.
	Physician/surgeon fees	No charge*	Not covered	—————none—————
If you need immediate medical attention	Emergency room care	\$300/visit for facility Deductible does not apply No charge for professional	\$300/visit for facility Deductible does not apply No charge for professional	OON non-emergency not covered if not a true emergency
	Emergency medical transportation	\$100/visit* Deductible does not apply for air ambulance	\$100/visit for air ambulance Not covered for other ambulance services	—————none—————
	Urgent care	\$60/visit*	Not covered	—————none—————

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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 have a hospital stay	Facility fee (e.g., hospital room)	\$500/visit*	Not covered	Pre-certification required. Failure to pre-certify will result to the denial of claim until pre-certification is approved and on file. Failure to request extension of original certification will result in denial of benefits for the remainder of the hospital stay.
	Physician/surgeon fees	No charge	Not covered	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35/visit* for office visit, telephone consultation / telemedicine (PCP) family psychotherapy, intensive outpatient services, and partial hospitalization; \$55/visit* for telephone consultation / telemedicine (specialist); \$200/visit* for outpatient facility	Not covered	Pre-certification required for partial hospitalization and intensive outpatient services in order to avoid denial of the claim.
	Inpatient services	\$500/visit* for inpatient	Not covered	Pre-certification required for inpatient in order to avoid denial of the claim.
If you are pregnant	Office visits	No charge for preventive prenatal office visits; \$35/visit* for non-preventive prenatal office visits	Not covered	Cost sharing does not apply for preventive services . Depending on the type of service, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	—————none—————
	Childbirth/delivery facility services	No charge for birthing center	Not covered	Pre-certification required for inpatient hospital in order to avoid denial of the claim.

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* After [deductible](#)

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)	
		\$500/visit* for inpatient hospital		
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Maximum 40 visits/year combined with Home Visits.
	Rehabilitation services	\$500/visit* for inpatient	Not covered	Maximum 50 visits/year combined for aquatic, cognitive, occupational, physical, and speech therapies and pulmonary rehabilitation. Pre-certification required for inpatient in order to avoid denial of the claim
		No charge* for aquatic, cognitive, occupational, physical and speech therapies (facility), cardiac rehabilitation (facility)		
	Habilitation services	\$55/visit* for pulmonary rehabilitation (facility), aquatic, cognitive, occupational, physical and speech therapies (professional), and cardiac rehabilitation (professional)	Not covered	_____none_____
		\$55/visit*		
	Skilled nursing care	\$200/visit*	Not covered	Maximum 100 days/year. Pre-certification required in order to avoid denial of the claim.
	Durable medical equipment	\$50/visit*	Not covered	Pre-certification required for all rentals and for purchases in excess of \$1,500 in order to avoid denial of the claim.
Hospice services	\$100/visit* for inpatient hospice	Not covered	Hospice Care is limited to terminally ill members with a life expectancy of six (6) months or less. Maximum 8 days/year for inpatient respite care. Maximum 3 visits (individual or family)/year for bereavement counseling.	
	No charge for outpatient hospice			

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* After [deductible](#)

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)	
		\$40/visit* for all other hospice services		Pre-certification required for inpatient and outpatient care in order to avoid denial of the claim.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered under the medical plan.
	Children's glasses	Not covered	Not covered	Not covered under the medical plan.
	Children's dental check-up	Not covered	Not covered	Not covered under the medical plan.

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 .)		
<ul style="list-style-type: none"> Cosmetic surgery, unless restoring bodily function or correcting deformity resulting from non-cosmetic surgery, accidental injury, or congenital defect Dental care (adult & child), unless due to accidental injury or trauma 	<ul style="list-style-type: none"> Glasses (adult & child), unless due to accidental injury or intraocular surgery Hearing aids, unless due to accidental injury Infertility treatment Long-term care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S., if purpose of travel is to receive care Routine eye care (adult & child) Routine foot care Weight loss programs, except as covered under the Affordable Care Act

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Acupuncture, performed for a pain diagnosis Bariatric surgery, for morbid obesity 	<ul style="list-style-type: none"> Chiropractic care (maximum 20 visits/year) 	<ul style="list-style-type: none"> Private-duty nursing

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 on how 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: Additionally, a consumer assistance program can help you file your appeal. Contact the U.S. Department of Labor, Employee Benefits Security Administration, located at 200 Constitution, Ave., NW in Washington, DC 20210 by calling (866)-444-3272 or by visiting <http://www.askebsa.dol.gov>.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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* After [deductible](#)

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **866-871-0839**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **866-871-0839**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **866-871-0839**.

Pennsylvania Dutch (Deitsch): Fer Hilf griegie in Deitsch, ruf **866-871-0839** uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni **866-871-0839**.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye **866-871-0839**.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang **866-871-0839**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **866-871-0839**.

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 [MyNIAMBenefits.com](https://www.niam.com/MyNIAMBenefits.com) or call **866-871-0839**

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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	\$500
■ Specialist copayment	\$55
■ Hospital (facility) copayment	\$300
■ Other coinsurance	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	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$510
Copayments	\$640
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,210

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$55
■ Hospital (facility) copayment	\$300
■ Other coinsurance	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	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$575
Copayments	\$410
Coinsurance	\$760
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,745

Mia's Simple Fracture

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$55
■ Hospital (facility) copayment	\$300
■ Other coinsurance	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	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$510
Copayments	\$930
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,440

*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.