



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](http://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](http://www.healthcare.gov/sbc-glossary) or call 866-871-0839 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. All in-network benefits and prescription drug benefits are covered before you meet your <a href="#">deductible</a> . Out-of-network emergency room care and air ambulance transportation are also covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,000 individual / \$12,000 family for in-network providers.	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> ?	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 <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.cfablue.com">www.cfablue.com</a> or call 1-866-871-0839 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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	Not covered	Primary care includes physicians in general practice, family practice, internal medicine, pediatrics, obstetrics/gynecology, or geriatrics; and nurse practitioners.
	<a href="#">Specialist</a> visit	\$50/visit	Not covered	—————none—————
	<a href="#">Preventive care/screening</a> /immunization	No charge	Not covered	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, ultrasounds, etc.)	Physician Office visit copay \$30 PCP/ \$50 Specialist; No charge for Outpatient Hospital Facility; \$20/visit for Independent Facility	Not covered	—————none—————
	Imaging (CT/PET scans, MRIs)	Physician Office visit copay \$30 PCP/ \$50 Specialist; \$50/visit for Outpatient Hospital Facility;	Not covered	Pre-certification required in order to avoid denial of the claim.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> .	Generic drugs	\$10/prescription (retail), \$20/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 \$50/prescription (retail), \$100/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	

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)	
	Non-preferred brand drugs	30% coinsurance to a maximum of \$100/prescription (retail), \$200/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	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).  <b><u>Prescription Drug Out-of-Pocket Maximum: \$1,900 individual / \$3,800 family</u></b>
	<a href="#">Specialty drugs</a>	20% coinsurance to a maximum of \$200/prescription	Applicable copayment, plus charges in excess of the allowed amount	CVS Specialty Pharmacy required. Pre-certification required in order to avoid denial of the claim. Quantities vary.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$50/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—————
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200/visit for facility No charge for professional	\$200/visit for facility No charge for professional	OON non-emergency not covered if not a true emergency
	<a href="#">Emergency medical transportation</a>	\$100/visit	\$100/visit for air ambulance Not covered for other ambulance services	—————none—————
	<a href="#">Urgent care</a>	\$50/visit	Not covered	—————none—————
<b>If you have a hospital stay</b>	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—————

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	\$30/visit for office visit, telephone consultation / telemedicine (PCP) family psychotherapy, intensive outpatient services, and partial hospitalization;  \$50/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.
<b>If you are pregnant</b>	Office visits	No charge for preventive prenatal office visits; \$30/visit for non-preventive prenatal office visits	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of service, a <a href="#">copayment</a> or <a href="#">coinsurance</a> 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 \$500/visit for inpatient hospital	Not covered	Pre-certification required for inpatient hospital in order to avoid denial of the claim.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	Not covered	Maximum 40 visits/year combined with Home Visits.
	<a href="#">Rehabilitation services</a>	\$500/visit for inpatient	Not covered	Maximum 50 visits/year combined for aquatic, cognitive, occupational, physical, and speech therapies and pulmonary rehabilitation.

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)	
		No charge for aquatic, cognitive, occupational, physical and speech therapies (facility), cardiac rehabilitation (facility)  \$50/visit for pulmonary rehabilitation (facility), aquatic, cognitive, occupational, physical and speech therapies (professional), and cardiac rehabilitation (professional)		Pre-certification required for inpatient in order to avoid denial of the claim
	<a href="#">Habilitation services</a>	\$50/visit	Not covered	—————none—————
	<a href="#">Skilled nursing care</a>	\$200/visit	Not covered	Maximum 100 days/year. Pre-certification required in order to avoid denial of the claim.
	<a href="#">Durable medical equipment</a>	\$50/item	Not covered	Pre-certification required for all rentals and for purchases in excess of \$1,500 in order to avoid denial of the claim.
	<a href="#">Hospice services</a>	\$100/visit for inpatient hospice  No charge for outpatient hospice  \$40/visit for all other hospice services	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. Pre-certification required for inpatient and outpatient care in order to avoid denial of the claim.
<b>If your child needs dental or eye care</b>	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](#).)

- 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
- Glasses (adult & child), unless due to accidental injury or intraocular surgery
- Hearing aids, unless due to accidental injury
- Infertility treatment
- Long-term care
- 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.)

- Acupuncture, performed for a pain diagnosis
- Bariatric surgery, for morbid obesity
- Chiropractic care (maximum 20 visits/year)
- 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](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 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](#).

### 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 (Deutsch): Fer Hilf griegie in Deutsch, ruf **866-871-0839** uff.

Samoa (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, â'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.*



## 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>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
In this example, Peg would pay:	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,080
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,080</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>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
In this example, Joe would pay:	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$780
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$780</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>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Mia would pay:	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1280
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1280</b>