**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?** | **$0.** | See the Common Medical Events chart below for your costs for services this plan covers. |
| **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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$6,000** individual / **$12,000** 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). 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **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 | $30/visit | Not covered | Primary care includes physicians in general practice, family practice, internal medicine, pediatrics, obstetrics/gynecology, or geriatrics; and nurse practitioners. |
| | Specialist visit | $50/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) | $20/visit for facility<br>No charge for professional | Not covered | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | $50/visit for facility<br>No charge for professional | Not covered | Pre-certification required in order to avoid denial of the claim. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.caremark.com. | 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).<br><br>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).<br><br>**Prescription Drug Out-of-Pocket Maximum: $1,900** individual / **$3,800** family |
| | 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 | |
| | 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 | |
| | Specialty drugs | 20% coinsurance to a maximum of $200/prescription | Applicable copayment, plus charges in excess of the allowed amount | CVS Specialty Pharmacy required.<br>Pre-certification required in order to avoid denial of the claim.<br>Quantities vary. |

| 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 outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $50/visit for ambulatory surgical facility<br>$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 | $200/visit for facility<br>No charge for professional | $200/visit for facility<br>No charge for professional | OON non-emergency not covered if not a true emergency |
| | Emergency medical transportation | $100/visit | $100/visit for air ambulance<br>Not covered for other ambulance services | ——————none—————— |
| | Urgent care | $50/visit | Not covered | ——————none—————— |
| **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 | $30/visit for office visit, telephone consultation / telemedicine (PCP) family psychotherapy, intensive outpatient services, and partial hospitalization;<br><br>$50/visit for telephone consultation / telemedicine (specialist);<br><br>$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. |

| 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) | |
| | 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;<br>$30/visit for non-preventive prenatal office visits | Not covered | Cost sharing does not apply for preventive services.<br>Depending on the type of service, a copayment or coinsurance may apply.<br>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<br>$500/visit for inpatient hospital | Not covered | Pre-certification required for inpatient hospital in order to avoid denial of the claim. |
| **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<br><br>No charge for aquatic, cognitive, occupational, physical and speech therapies (facility), cardiac rehabilitation (facility)<br><br>$50/visit for pulmonary rehabilitation (facility), aquatic, cognitive, occupational, physical and speech therapies (professional), and cardiac rehabilitation (professional) | Not covered | Maximum 50 visits/year combined for aquatic, cognitive, occupational, physical, and speech therapies and pulmonary rehabilitation.<br>Pre-certification required for inpatient in order to avoid denial of the claim |
| | Habilitation services | $50/visit | Not covered | ——————none—————— |
| | Skilled nursing care | $200/visit | Not covered | Maximum 100 days/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) | |
| | | | | Pre-certification required in order to avoid denial of the claim. |
| | Durable medical equipment | $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. |
| | Hospice services | $100/visit for inpatient hospice<br><br>No charge for outpatient hospice<br><br>$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.<br>Maximum 8 days/year for inpatient respite care.<br>Maximum 3 visits (individual or family)/year for bereavement counseling.<br>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.)**

- 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. 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.

**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 griege 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, å'gang **866-871-0839**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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 plan's overall deductible** | **$0** |
| **Specialist *copayment*** | **$50** |
| **Hospital (facility) *copayment*** | **$500** |
| **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:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $1,080 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$1,080** |

### 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*** | **$50** |
| **Hospital (facility) *copayment*** | **$500** |
| **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:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $780 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$780** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist *copayment*** | **$50** |
| **Hospital (facility) *copayment*** | **$500** |
| **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:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $1280 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1280** |

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