



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, 1-718-513-2478. 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 1-718-513-2478 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network providers</a> : None <a href="#">Out-of-network providers</a> : Not Covered <b>Benefit Period: Calendar Year</b>	Generally, you must pay all of the costs from providers 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> . Embedded.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary/specialist care services are 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?	<b>Yes.</b> \$100 <a href="#">deductible</a> for Non-Generic Drugs.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network providers</a> : \$2,000 Individual / \$4,000 Family <a href="#">Out-of-network providers</a> : Not Covered	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. Embedded.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">Preauthorization</a> for services, 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. This plan uses the <b>Blue Cross Blue Shield PPO Network</b> . A list of <a href="#">network providers</a> can be found at <a href="http://www.bcbs.com">www.bcbs.com</a> or call 1-800-810-2583	This <a href="#">plan</a> uses a provider <a href="#">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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see a <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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> /per visit	Not Covered	None.
	<a href="#">Specialist</a> visit to treat an injury or illness	\$30 <a href="#">copay</a> /per 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 <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	<a href="#">Preauthorization</a> is required for Sleep Study or benefit will be denied.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	<a href="#">Preauthorization</a> is required or benefit will be denied.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ingenio-rx.com">www.ingenio-rx.com</a> call 1-833-271-2374	Generic drugs	\$15 <a href="#">copay</a> Retail \$37.50 <a href="#">copay</a> Mail Order	Not Covered	<b>\$100 deductible for Non-Generic Drugs.</b> Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription). If a prescription is filled with a non-generic drug when a generic equivalent exists, member will be responsible for the cost difference between the non-generic drug and the generic equivalent.
	Preferred brand drugs	\$35 <a href="#">copay</a> Retail after Rx Deductible \$87.50 <a href="#">copay</a> Mail Order after Rx Deductible	Not Covered	
	Non-preferred brand drugs	\$75 <a href="#">copay</a> Retail after Rx Deductible \$187.50 <a href="#">copay</a> Mail Order after Rx Deductible	Not Covered	
	<a href="#">Specialty drugs</a>	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required or benefit will be denied.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	Not Covered	None



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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$500 <a href="#">copay</a> /per visit		ER <a href="#">copay</a> is waived if admitted as inpatient. All facilities are covered as in-network subject to meeting “emergency” criteria.
	<a href="#">Emergency medical transportation</a>	\$500 <a href="#">copay</a> /per visit		
	<a href="#">Urgent care</a>	\$30 <a href="#">copay</a> /per visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required or benefit will be denied.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copay</a> /per visit	Not Covered	<a href="#">Preauthorization</a> is required or benefit will be denied.
	Office visit services	\$10 <a href="#">copay</a> /per visit	Not Covered	None
	Inpatient services	10% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required or benefit will be denied.
If you are pregnant	Office visits	\$10 <a href="#">copay</a> 1 <sup>st</sup> visit only	Not Covered	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Preauthorization</a> is required for inpatient stay.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	Not Covered	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required or benefit will be denied.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	Not Covered	Maximum 30 visits per therapy per benefit period. Includes physical therapy, speech therapy, and occupational therapy. <a href="#">Preauthorization</a> is required or benefit will be denied.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	Not Covered	



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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	Not Covered	Maximum 60 visits per benefit period. <a href="#">Preauthorization</a> is required or benefit will be denied.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required or benefit will be denied.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> is required or benefit will be denied.
If your child needs dental or eye care	Children's eye exam	Not Covered Except for ACA mandated services	Not covered	One vision screening for children 3-5 years is covered as a preventive service. Cost sharing does not apply for preventive services.
	Children's glasses	Not Covered	Not covered	No coverage for glasses
	Children's dental check-up	Not Covered Except for ACA mandated services	Not covered	Dental caries fluoride application for infants and children up to 5 years are covered as preventive services. Cost sharing does not apply for preventive services.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Advanced Infertility Services</li> <li>Bereavement Counseling</li> <li>Biofeedback</li> <li>Cosmetic Surgery</li> <li>Gene or Cellular therapy / Treatments</li> <li>Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility Treatment</li> <li>Long-Term Care</li> <li>Non-Emergency Care in the ER setting</li> <li>Non-Emergency Care when traveling outside the US</li> <li>Private Duty Nursing</li> <li>Respite Care</li> </ul>	<ul style="list-style-type: none"> <li>Routine Dental Care (adult)</li> <li>Routine Foot Care</li> <li>Specialty Medication</li> <li>TMJ Appliances</li> <li>Vision Exam &amp; Hardware</li> <li>Voluntary Sterilization (except as required by PPACA)</li> <li>Weight Loss Programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic Care (Limited to 25 visits per calendar year)</li> </ul>		

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). For more information on your rights to continue coverage, contact the plan at 1-718-513-2478. 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: 1-718-513-2478.

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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual mark 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 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 1-718-513-2478

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-718-513-2478

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-718-513-2478

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-718-513-2478

*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>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### 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>\$12,687</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$21
Coinsurance	\$846
What isn't covered	
Limits or exclusions	\$61
<b>The total Peg would pay is</b>	<b>\$928</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>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### 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>\$5,601</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$100
Copayments	\$734
Coinsurance	\$79
What isn't covered	
Limits or exclusions	\$22
<b>The total Joe would pay is</b>	<b>\$935</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>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### 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>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$1,234
Coinsurance	\$29
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,263</b>