





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, call 1-877-208-5952. 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 1-877-208-5952 to request a copy. For assistance with claims and medical benefits contact Valenz Navcare Concierge Services at 1-877-208-5952. For **Preauthorization** or for **Case Management** contact Healthlink at 1-877-284-0102.


Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network providers</a> : \$2,500 individual / \$5,000 family <a href="#">Out-of-network providers</a> : \$5,000 individual / \$10,000 family <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="#">Prescription drugs</a> , <a href="#">Preventive care</a> , Emergency Room/Urgent care, primary / specialist office visits, pre/post-natal care, routine eye exam and rehabilitation services are covered before you meet your deductible.	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> ?	<a href="#">Network providers</a> : \$5,000 individual / \$10,000 family <a href="#">Out-of-network providers</a> : \$10,000 individual / \$20,000 family	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.empireblue.com">www.empireblue.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	<b>Professional Non-Facility based services:</b> \$ 45 <a href="#">copay</a> /per visit <b>Facility based services:</b> \$ 45 <a href="#">copay</a> /per visit <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after deductible	Copay applies per visit regardless of what services are rendered.
	<a href="#">Specialist</a> visit to treat an injury or illness	<b>Professional Non-Facility based services:</b> \$ 65 <a href="#">copay</a> /per visit <b>Facility based services:</b> \$ 65 <a href="#">copay</a> /per visit <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after deductible	
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a> after deductible	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)	<b>Lab, Pathology &amp; Radiology: Office Setting:</b> \$ 75 <a href="#">copay</a> /per visit <b>Lab, Pathology &amp; Radiology: Independent Lab &amp; Facility Based Services:</b> \$ 75 <a href="#">copay</a> /per visit <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Imaging (CT/PET scans, MRIs)	25% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for PET/CAT/MRI/MRA. If Preauthorization is not obtained benefit may be reduced by \$400 of the total cost of the service.

 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)	
<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.carelonrx.com">www.carelonrx.com</a> or call 1-833-271-2374	Generic drugs (Tier 1)	\$ 15 <a href="#">copay</a> Retail \$ 30 <a href="#">copay</a> Mail Order	\$ 15 <a href="#">copay</a> , then 25% coinsurance (Retail)	<b>Deductible does not apply.</b> Dispense as Written (DAW) provision does apply. Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). No cost for ACA preventive care drugs. <a href="#">Preauthorization</a> is required for injectables over \$2,000 per drug per month.
	Preferred brand drugs (Tier 2)	\$ 50 <a href="#">copay</a> Retail \$ 70 <a href="#">copay</a> Mail Order	\$ 50 <a href="#">copay</a> , then 25% coinsurance (Retail)	
	Non-preferred brand drugs (Tier 3)	\$ 85 <a href="#">copay</a> Retail \$ 140 <a href="#">copay</a> Mail Order	\$ 85 <a href="#">copay</a> , then 25% coinsurance (Retail)	
	<a href="#">Specialty drugs</a> (Tier 4)	\$ 90 <a href="#">copay</a> Retail \$ 180 <a href="#">copay</a> Mail Order	\$ 90 <a href="#">copay</a> , then 25% coinsurance (Retail)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for certain services and surgeries, including infusion therapy costing over \$2,000 per drug per month. If <a href="#">Preauthorization</a> is not obtained benefits may be reduced by \$400 of the total cost of service. See your plan document for details.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$ 400 <a href="#">copay</a> /per visit <i>Savings Plus Plan Benefit</i>		ER <a href="#">copay</a> is waived if admitted as inpatient. All facilities are covered as in-network subject to meeting “emergency” criteria. Non-participating providers paid at the participating provider level of benefits.
	<a href="#">Emergency medical transportation</a>	25% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>		
	<a href="#">Urgent care</a>	\$ 25 <a href="#">copay</a> /per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Copay applies per visit regardless of what services are rendered.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$ 200 <a href="#">copay</a> /per admission, then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit may be reduced by \$400 of the total cost of the service. To speak with a Case Manager, contact Healthlink Case Management Services at 1-877-284-0102
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</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 need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Professional Non-Facility based services:</b> \$ 45 <a href="#">copay</a> /per visit <b>Facility based services:</b> \$ 45 <a href="#">copay</a> /per visit <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	Inpatient services	\$ 200 <a href="#">copay</a> /per admission, then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit may be reduced by \$400 of the total cost of the service. To speak with a Case Manager, contact Healthlink Case Management Services at 1-877-284-0102
If you are pregnant	Office visits	<b>Professional Non-Facility based services:</b> No Charge after initial \$ 45 <a href="#">copay</a> <b>Facility based services:</b> No Charge after initial \$ 45 <a href="#">copay</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<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 over 48 hours for a vaginal delivery or 96 hours for a cesarean section. If <a href="#">Preauthorization</a> is not obtained benefit may be reduced by \$400 of the total cost of the service. Newborn does not count toward the mother's expense; therefore the family <a href="#">deductible</a> may apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	\$ 200 <a href="#">copay</a> / per admission then 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maximum 60 visits per calendar year. <a href="#">Preauthorization</a> is required or benefit may be reduced by \$400 of the total cost of the service. To speak with a Case Manager, contact Healthlink Case Management Services at 1-877-284-0102

 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="#">Rehabilitation services</a>	\$ 65 <a href="#">copay</a> /per visit <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maximum 60 visits per calendar year per therapy (Physical therapy, speech therapy, and occupational therapy)
	<a href="#">Habilitation services</a>	\$ 65 <a href="#">copay</a> /per visit <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit may be reduced by \$400 of the total cost of the service.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maximum 60 visits per calendar year. <a href="#">Preauthorization</a> is required. If <a href="#">Pre-authorization</a> is not obtained benefits may be reduced by \$400 of the total cost of the service. .
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required items including electric/motorized scooters, wheelchairs, and pneumatic compression devices. If <a href="#">Preauthorization</a> is not obtained benefits may be reduced by \$400 of the total cost of the service.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Bereavement counseling is covered if received within 6 months of death. <a href="#">Preauthorization</a> is not obtained benefits may be reduced by \$400 of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	No Charge	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Coverage limited to one exam every 24 months
	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 [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |   |  |   |
|---|--|---|
| • Acupuncture (excluding anesthetic usage)  | • Hearing aids                             | • Non-Emergency care when traveling outside the U.S.                      |
| • Applied Behavioral Analysis (ABA therapy) | • Infertility treatment (except diagnosis) | • Routine Dental Care (Adult & Child)                                     |
| • Bariatric Surgery                         | • Long-term care                           | • Routine Foot Care (except for metabolic or peripheral vascular disease) |
| • Cosmetic Surgery                          | • Maternity care for dependent daughters   | • Weight loss programs  |
| • Genetic Testing                           | • Non-Emergency use of Emergency services  |   |
| • Glasses (Adult & Child)                   |  |   |

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

- |   |   |                        |
|---|---|------------------------|
| • Chiropractic Care<br>(limited to 25 visits per calendar year) | • Dental Care Non-Routine Services & Injury | • 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: 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 1-877-208-5952. 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: 1-877-208-5952.

**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 1-877-208-5952

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-208-5952

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-208-5952

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-208-5952

*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>	\$2,500
■ <a href="#">Specialist copayment</a>	\$65
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### 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	\$2,500
Copayments	\$994
Coinsurance	\$1,192
What isn't covered	
Limits or exclusions	\$61
<b>The total Peg would pay is</b>	<b>\$4,747</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>	\$2,500
■ <a href="#">Specialist copayment</a>	\$65
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### 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*	\$790
Copayments	\$1,840
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$22
<b>The total Joe would pay is</b>	<b>\$2,652</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>	\$2,500
■ <a href="#">Specialist copayment</a>	\$65
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### 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*	\$1,235
Copayments	\$930
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,165</b>