




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 or call 1-718-513-2478 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network providers : \$2,000 individual / \$4,000 family Out-of-Network providers : \$2,000 individual / \$4,000 family	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 , the overall family deductible must be met before the plan begins to pay. Non-Embedded. Benefit Period: Calendar Year
Are there services covered before you meet your deductible ?	Yes. In Network Preventive care services are 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 ?	Network providers : \$5,000 individual / \$10,000 family Out-of-Network providers : \$10,000 individual / \$20,000 family	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members in this plan , the overall family out-of-pocket limit must be met. Non-Embedded.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, penalties for failure to obtain Preauthorization for services, 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. This plan uses the Blue Cross Blue Shield PPO Network. A list of network providers can be found at www.bcbs.com or call 1-800-810-2583	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.
Do you need a referral to see a specialist ?	No	You can see a specialist you choose without a referral

 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 provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance after deductible	30% coinsurance after deductible	None
	Specialist visit to treat an injury or illness	10% coinsurance after deductible	30% coinsurance after deductible	None
	Preventive care/screening/immunization	No charge	30% coinsurance after deductible	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	30% coinsurance after deductible	None
	Imaging (CT/PET scans, MRI)	10% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required or benefit will be denied
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.magellanrx.com or call 1-800-443-5715	Generic drugs (Tier 1)	\$10 copay Retail after Plan Deductible \$25 copay Mail Order after Plan Deductible	30% coinsurance after deductible	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. Rx copays apply after overall deductible is met.
	Preferred brand drugs (Tier 2)	\$45 copay Retail after Plan Deductible \$112.50 copay Mail Order After Plan Deductible	30% coinsurance after deductible	
	Non-preferred brand drugs (Tier 3)	\$75 copay Retail after Plan Deductible \$187.50 copay Mail Order after Plan Deductible	30% coinsurance after deductible	
	Specialty drugs (Tier 4)	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required or benefit will be denied
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance after deductible	None

For more information about limitations and exceptions, contact 1-718-513-2478

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	Emergency room care	10% coinsurance after deductible		All facilities are covered as in-network subject to meeting “emergency” criteria Network deductible applies for Out-of-Network
	Emergency medical transportation	10% coinsurance after deductible		
	Urgent care	10% coinsurance after deductible	30% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required or benefit will be denied
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance after deductible	30% coinsurance after deductible	None
	Inpatient services	10% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required or benefit will be denied
If you are pregnant	Office visits	10% coinsurance after deductible	30% coinsurance after deductible	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for inpatient stay.
	Childbirth/delivery professional services	10% coinsurance after deductible	30% coinsurance after deductible	
	Childbirth/delivery facility services	10% coinsurance after deductible	30% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required or benefit will be denied
	Rehabilitation services	10% coinsurance after deductible	30% coinsurance after deductible	Maximum 30 visits per therapy per benefit period. Includes physical therapy, speech therapy, and occupational therapy. Preauthorization is required or benefit will be denied.
	Habilitation services	10% coinsurance after deductible	30% coinsurance after deductible	
	Skilled nursing care	10% coinsurance after deductible	30% coinsurance after deductible	Maximum 60 visits per benefit period. Preauthorization is required or benefit will be denied
	Durable medical equipment	10% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required or benefit will be denied
	Hospice services	10% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required or benefit will be denied

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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 your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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"> Acupuncture Advanced Infertility Services Bariatric Surgery Bereavement Counseling Biofeedback Cosmetic Surgery Hearing Aids 	<ul style="list-style-type: none"> Long-Term Care Maternity Care for dependent daughters Non-Emergency Care in the ER setting Non-Emergency Care outside the US Nutritional Counseling (Non-Diabetic) Private Duty Nursing Respite Care 	<ul style="list-style-type: none"> Routine Dental Care Routine Foot Care Specialty Medication TMJ Appliances Vision Exam & Hardware Voluntary Sterilization (except as required by PPACA) Weight Loss Programs 	
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"> Chiropractic Care (25 visits per Benefit Period) 			

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-718-513-2478. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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](#). For more information about limitations and exceptions, contact 1-718-513-2478

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): Dinek'ehgo 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 plan's overall deductible	\$2,500
■ Specialist copayment	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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*)

Total Example Cost	\$12,840
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,500
Copayments	\$40
Coinsurance	\$1,172
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,772

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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*)

Total Example Cost	\$7,460
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In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$2,500
Copayments	\$895
Coinsurance	\$279
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$3,730

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,500
■ Specialist copayment	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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*)

Total Example Cost	\$2,010
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In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$1,733
Copayments	\$0
Coinsurance	\$193
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925