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: Not Covered Benefit Period: Calendar Year	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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meet the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Prescription drugs, Preventive care and primary 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: $7,850 Individual / $15,700 Family Out-of-network providers: Not Covered	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 limit until the overall family out-of-pocket limit has been met.
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	$35 copay/per visit	Not Covered	None
	Specialist visit to treat an injury or illness	$60 copay/per 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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Hospital Setting: 30% coinsurance after deductible All Other: No Charge	Not Covered	Preauthorization is required for Sleep Study or benefit will be denied.
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	Not Covered	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)	$15 copay Retail $30 copay Mail Order	Not Covered	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 (Tier 2)	$45 copay Retail $90 copay Mail Order	Not Covered	
	Non-preferred brand drugs (Tier 3)	$75 copay Retail $150 copay Mail Order	Not Covered	
	Specialty drugs (Tier 4)	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	Not Covered	Preauthorization is required or benefit will be denied.
	Physician/surgeon fees	30% coinsurance after deductible	Not Covered	None

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	$300 copay/per visit		In-Network ER copay is waived if admitted as inpatient. All facilities are covered as in-network subject to meeting "emergency" criteria.
	Emergency medical transportation	$300 copay/per trip		All facilities are covered as in-network subject to meeting "emergency" criteria.
	Urgent care	$60 copay/per visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	Not Covered	Preauthorization is required or benefit will be denied.
	Physician/surgeon fees	30% coinsurance after deductible	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/per visit	Not Covered	None
	Inpatient services	30% coinsurance after deductible	Not Covered	Preauthorization is required or benefit will be denied.
If you are pregnant	Office visits	$35 copay / 1st Visit only	Not Covered	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 over 48 hours for a vaginal delivery or 96 hours for cesarean section.
	Childbirth/delivery professional services	$35 copay / 1st Visit only	Not Covered	
	Childbirth/delivery facility services	30% coinsurance after deductible	Not Covered	
If you need help recovering or have other special health needs	Home health care	$60 copay/per visit	Not Covered	Maximum 60 visits per calendar year. Preauthorization is required or benefit will be denied.
	Rehabilitation services	$60 copay/per visit	Not Covered	Maximum 30 visits per calendar year per therapy. Includes physical therapy, speech therapy, and occupational therapy. Preauthorization is required or benefit will be denied.
	Habilitation services	$60 copay/per visit	Not Covered	

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)	
	Skilled nursing care	30% coinsurance after deductible	Not Covered	Maximum 60 visits calendar year. Preauthorization is required or benefit will be denied.
	Durable medical equipment	30% coinsurance after deductible	Not Covered	Preauthorization is required or benefit will be denied.
	Hospice services	30% coinsurance after deductible	Not Covered	Preauthorization is required or benefit will be denied.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not a Covered Service
	Children's glasses	Not Covered	Not Covered	Not a Covered Service
	Children's dental check-up	Not Covered	Not Covered	Not a Covered Service

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.)

- Advanced Infertility Services
- Bariatric Surgery
- Bereavement Counseling
- Biofeedback
- Cosmetic Surgery
- Dental Care (Routine)
- Hearing Aids
- Long-Term Care
- Maternity Care for the dependent daughters
- Non-Emergency Care outside the U.S.
- Non-Emergency Care in the ER setting
- Private-Duty Nursing
- Respite Care
- Routine Foot Care
- Specialty Drugs
- TMJ Treatment
- Vision Exam and Hardware
- Voluntary Sterilization
- Weight Loss Programs

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

- Acupuncture
- Chiropractic Care (25 visits per calendar year)

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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	$2,000
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$12,687**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$46
Coinsurance	$1,518
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$3,625**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$5,601**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$790
Copayments	$1,124
Coinsurance	$0
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$1,936**

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

The plan's overall deductible	$2,000
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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*	$291
Copayments	$1,187
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,478**

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