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 **877-889-2478**. 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 **877-889-2478** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** individual / **$6,000** family for in-network providers and **$4,000** individual / **$6,000** family for out-of-network providers. Copayments, pre-certification penalties, and balance-billed charges don't count toward the deductible.	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 meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Urgent care, emergency room care professional and prescription drugs are covered before you meet your deductible. In-network, office visits, preventive care, diagnostic tests professional services, delivery, rehabilitation and habilitation therapies 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 deductible for specific services.
What is the out-of-pocket limit for this plan?	**$6,250** individual / **$12,500** family for in-network providers and **$19,800** individual / **$39,600** family for out-of-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?	Pre-certification penalties, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

For more information about limitations and exceptions, see plan or policy document at www.cfablue.com or call 877-889-2478
* After deductible

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.cfablue.com** or call **1-877-889-2478** 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.
Do you need a referral to see a specialist?	No.	You can see the 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
		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	$35/visit Deductible does not apply 20% coinsurance * for telephone consultation Same as any covered service for telemedicine (non-designated provider)	40% coinsurance * 40% coinsurance * for telephone consultation Same as any covered service for telemedicine (non-designated provider)	Primary care includes physicians in general practice, family practice, internal medicine, pediatrics, obstetrics/gynecology, or geriatrics; and nurse practitioners.
	Specialist visit	$55/visit Deductible does not apply	40% coinsurance *	Acupuncture not covered.
	Preventive care/screening/ immunization	No charge Deductible does not apply	40% coinsurance *	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.

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 a test	Diagnostic test (x-ray, blood work)	20% coinsurance * for facility No charge, deductible does not apply for professional	40% coinsurance *	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance *	40% coinsurance *	Pre-certification required (penalty applies).
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$10/prescription (retail) $20/prescription (mail order) Deductible does not apply	Applicable copayment, plus charges in excess of the allowed amount	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). If you purchase a brand name drug in lieu of a generic drug, your copayments may be higher, as described in the plan document. 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).
	Preferred brand drugs	$35/prescription (retail) $70/prescription (mail order) Deductible does not apply	Applicable copayment, plus charges in excess of the allowed amount	
	Non-preferred brand drugs	$75/prescription (retail) $150/prescription (mail order) Deductible does not apply	Applicable copayment, plus charges in excess of the allowed amount	
	Specialty drugs	Applicable copayment	Applicable copayment, plus charges in excess of the allowed amount	

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)	20% coinsurance, deductible does not apply for ambulatory surgical facility $500 copayment then 20% coinsurance * for outpatient hospital	40% coinsurance *	Pre-certification required (penalty applies).
	Physician/surgeon fees	20% coinsurance *	40% coinsurance *	——————none——————
If you need immediate medical attention	Emergency room care	20% coinsurance * for facility 20% coinsurance, deductible does not apply for professional	20% coinsurance * for facility 20% coinsurance, deductible does not apply for professional	In-network deductible applies to out-of-network emergency room care.
	Emergency medical transportation	20% coinsurance *	20% coinsurance *	In-network deductible applies to out-of-network ambulance. Pre-certification required for air ambulance (penalty applies).
	Urgent care	$75/visit Deductible does not apply	$75/visit Deductible does not apply	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance *	40% coinsurance *	Pre-certification required. Failure to pre-certify will reduce benefits by 50%. Failure to request extension of original certification will result in denial of benefits for the remainder of the hospital stay.
	Physician/surgeon fees	20% coinsurance *	40% coinsurance *	——————none——————

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$35/visit Deductible does not apply $500/visit, then 20% coinsurance * for outpatient facility 20% coinsurance * for other outpatient services	40% coinsurance *	Maximum 60 visits/year for intensive outpatient services.
	Inpatient services	20% coinsurance * for inpatient hospital 20% coinsurance, deductible does not apply for residential treatment facility	40% coinsurance *	Pre-certification required (penalty applies).
If you are pregnant	Office visits	20% coinsurance Deductible does not apply	40% coinsurance *	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance Deductible does not apply	40% coinsurance *	——————none——————
	Childbirth/delivery facility services	20% coinsurance *	40% coinsurance *	Pre-certification is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid a 50% penalty.

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 need help recovering or have other special health needs	Home health care	20% coinsurance *	40% coinsurance *	Maximum 60 visits/year.
	Rehabilitation services	$55/visit Deductible does not apply 20% coinsurance * for inpatient, cardiac rehabilitation and pulmonary rehabilitation	40% coinsurance *	Maximum 37 visits/year for occupational, physical, respiratory, and speech therapies. Maximum 20 visits/year for pulmonary rehabilitation. Maximum 36 visits/year for cardiac rehabilitation. Pre-certification required for inpatient (penalty applies).
	Habilitation services	20% coinsurance Deductible does not apply	40% coinsurance *	——————none——————
	Skilled nursing care	20% coinsurance *	40% coinsurance *	Pre-certification required (penalty applies).
	Durable medical equipment	20% coinsurance *	40% coinsurance *	Pre-certification required in excess of $1,000 (penalty applies). Limited to one single purchase every 3 calendar years.
	Hospice services	20% coinsurance *	40% coinsurance *	Maximum 180 days/lifetime combined for inpatient and outpatient. Maximum 45 reserve days/lifetime. Maximum 14 days/lifetime for respite care. Pre-certification required for inpatient (penalty applies).
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.)

- Acupuncture
- Bariatric surgery
- 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
- Glasses (adult & child), unless due to accidental injury or intraocular surgery
- Infertility treatment (except for diagnostic evaluation and testing)
- Long-term care
- Non-emergency care when traveling outside the U.S., if purpose of travel is to receive care
- Private-duty nursing
- Routine eye care (adult & child)
- Routine foot care
- Weight loss programs

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

- Chiropractic care (maximum 24 visits/year)
- Hearing aids, for children under 19 (maximum one aid/ear every 36 months up to $3,000)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 **877-889-2478**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **877-889-2478**.

Chinese (中文): **如果需要中文的帮助**，请拨打这个号码 **877-889-2478**..

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **877-889-2478**.

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*	**$55**
Hospital (facility) *coinsurance*	**20%**
Other *coinsurance*	**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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,110**

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*	**$55**
Hospital (facility) *coinsurance*	**20%**
Other *coinsurance*	**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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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

The plan's overall deductible	**$2,000**
Specialist *copayment*	**$55**
Hospital (facility) *coinsurance*	**20%**
Other *coinsurance*	**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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,700
Copayments	$400
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,180**

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