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, for medical visit www.bcbsal.org or call 1-877-733-4375, or for Rx visit www.caremark.com or call 1-855-310-4418. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Combined Medical & Rx Drug: **$1,500**/ Individual or **$3,000**/ Family coverage In-Network. **$3,000**/Individual or **$6,000**/ Family coverage Out-of-Network.	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.
Are there services covered before you meet your deductible?	Yes. 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?	Combined Medical & Rx Drug: **$3,750**/ Individual or **$7,500**/ Family coverage In-Network; **$7,500**/ Individual or **$15,000**/ Family coverage Out-of-Network.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties, 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. See www.bcbsal.org or call 1-877-733-4375 for medical. See www.caremark.com or call 1-855-310-4418 for Rx, 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
		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	20% coinsurance	40% coinsurance	Subject to overall deductible
	Specialist visit	20% coinsurance	40% coinsurance	Subject to overall deductible
	Preventive care/screening/ immunization	No charge	40% coinsurance	Subject to overall deductible for covered out-of-network services; 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)	20% coinsurance	40% coinsurance	Subject to overall deductible
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Subject to overall deductible; precertification may be required for coverage. Participants will be responsible for 100% of the total charges if the service is not medically necessary.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Non-Preventive Medications **Retail**: 20% coinsurance; with a $10 min / $25 max copay (Subject to deductible) **Mail Order**: 20% coinsurance; with a $20 min / $50 max copay (Subject to deductible) Preventive Medications **Retail** or **Mail Order**: 0% coinsurance (Not Subject to deductible)	Not Covered	Retail: covered up to 30-day supply. After 2 fills of a maintenance drug at retail, member required to get additional refills through mail order or a CVS retail pharmacy. Mail Order: Covered up to a 90-day supply. Clinical Programs including, but not limited to, Concurrent Drug Utilization Review. Coverage Management Programs including, but not limited to, Traditional Prior Authorization, SMART Prior Authorization, Quantity Duration, and Preferred Drug Step Therapy.
	Brand Formulary (Preferred brand drugs)	Non-Preventive Medications **Retail**: 30% coinsurance; with a $35 min / $75 max copay (Subject to deductible)	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at 1-888-242-0800.

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)	
		Mail Order: 30% coinsurance; with a $70 min / $150 max copay (Subject to deductible) Preventive Medications **Retail**: 30% coinsurance; with a $35 min / $75 max copay (Not Subject to deductible) **Mail Order**: 30% coinsurance; with a $70 min / $150 max copay (Not Subject to deductible)		Retail: covered up to 30-day supply. After 2 fills of a maintenance drug at retail, member required to get additional refills through mail order or a CVS retail pharmacy. Mail Order: Covered up to a 90-day supply. Clinical Programs including, but not limited to, Concurrent Drug Utilization Review. Coverage Management Programs including, but not limited to, Traditional Prior Authorization, SMART Prior Authorization, Quantity Duration, and Preferred Drug Step Therapy.
	Brand Non-Formulary (Non-Preferred brand drugs)	Non-Preventive Medications **Retail**: 40% coinsurance; with a $55 min / $120 max copay (Subject to deductible) **Mail Order**: 40% coinsurance; with a $110 min / $240 max copay (Subject to deductible) Preventive Medications **Retail**: 40% coinsurance; with a $55 min / $120 max copay (Not Subject to deductible) **Mail Order**: 40% coinsurance; with a $110 min / $240 max copay (Not Subject to deductible)	Not Covered	
	Specialty drugs	30-day supply – coinsurance same as non-specialty Generic, Brand Formulary, and Brand Non-Formulary	Not Covered	Must be obtained at CVS Specialty Pharmacy; limited to 30-day supply. Clinical Programs including, but not limited to, Concurrent Drug Utilization Review.

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)	
		medications. (Subject to deductible)		Coverage Management Programs including, but not limited to, Traditional Prior Authorization, SMART Prior Authorization, Quantity Duration, and Preferred Drug Step Therapy may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Subject to overall deductible
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Subject to overall deductible
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Subject to overall in-network deductible. If not a true medical emergency, a $200 penalty will apply if In-Network and a 20% benefit reduction will apply if Out-of-Network.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to overall in-network deductible
	Urgent care	20% coinsurance	40% coinsurance	Subject to overall deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Subject to overall deductible; Precertification may be required for coverage. Participants will be responsible for 100% of the total charges if the service is not medically necessary.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Subject to overall deductible
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Subject to overall deductible
	Inpatient services	20% coinsurance	40% coinsurance	Subject to overall deductible; Precertification may be required for coverage. Participants will be responsible for 100% of the total charges if the service is not medically necessary.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Subject to overall deductible. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Precertification may be required for coverage.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at 1-888-242-0800.

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 help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Subject to overall deductible; Precertification may be required for coverage. Participants will be responsible for 100% of the total charges if the service is not medically necessary.
	Rehabilitation services	20% coinsurance	40% coinsurance	Subject to overall deductible; limited to 60 visits each for physical, occupational and speech therapy per member/calendar year. Precertification may be required for coverage. Participants will be responsible for 100% of the total charges if the service is not medically necessary.
	Habilitation services	20% coinsurance	40% coinsurance	Subject to overall deductible; limited to 60 visits each for physical, occupational and speech therapy per member/calendar year. Precertification may be required for coverage. Participants will be responsible for 100% of the total charges if the service is not medically necessary.
	Skilled nursing care	20% coinsurance	40% coinsurance	Subject to overall deductible; limited to a maximum of 120 combined visits per member/per calendar year for skilled nursing care and inpatient rehabilitation. Precertification may be required for coverage. Participants will be responsible for 100% of the total charges if the service is not medically necessary.
	Durable medical equipment	20% coinsurance	40% coinsurance	Subject to overall deductible. Precertification may be required for coverage.
	Hospice services	20% coinsurance	40% coinsurance	Subject to overall deductible; Precertification may be required for coverage. Participants will be responsible for 100% of the total charges if the service is not medically necessary.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Limited to 8 services for ages 0-10 per child and 4 services for ages 11-21 per child when performed by a Pediatrician
	Children's glasses	Not Covered	Not covered	None
	Children's dental check-up	No Charge	Not covered	Oral evaluations limited to 4 services for ages birth to 6 years when performed by Pediatrician

* For more information about limitations and exceptions, see the plan or policy document at 1-888-242-0800.

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
- Cosmetic Surgery
- Dental Care (Adult)
- Glasses, child
- Long Term Care
- Routine eye care (Adult)
- 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.)

- Bariatric Surgery (Only morbid obesity in limited circumstances)
- Chiropractic Care (Limited to 24 visits per year)
- Hearing aids (Limitations apply)
- Infertility treatment (Limited to diagnosis only)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Precertification required for coverage)

* For more information about limitations and exceptions, see the plan or policy document at 1-888-242-0800.

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.. 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: the plan administrator at 1-888-242-0800. For medical benefit appeals, call 1-877-733-4375. For Rx Drug benefit appeals, call 1-855-310-4418. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 1-888-242-0800

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-242-0800

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-242-0800

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-242-0800

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	$1,500
Specialist copayment	$0
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	$1,500
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,760**

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

The plan's overall deductible	$1,500
Specialist copayment	$0
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*	$1,500
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,520**

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

The plan's overall deductible	$1,500
Specialist copayment	$0
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*	$1,500
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact your Human Resource Representative
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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