



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, [www.allmyhealth.com](http://www.allmyhealth.com) or call 844-946-6236. 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 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$6,350 individual/\$12,700 family <u>network</u> . \$7,500 individual/\$15,000 family out-of- <u>network</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive care services</u> and child's routine eye exam are covered before you meet your <u>network deductible</u> .  <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$6,350 individual/\$12,700 family <u>network out-of-pocket limit</u> , up to a total maximum out-of-pocket of \$6,350 individual/\$12,700 family.  \$15,000 individual/\$30,000 family out-of- <u>network</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Network</u> : <u>Premiums</u> , balance-billed charges, and health care this <u>plan</u> doesn't cover do not apply to your total maximum out-of-pocket.  <u>Out-of-network</u> : <u>Copayments</u> , <u>deductible</u> , <u>premiums</u> , balance-billed charges, <u>prescription drug</u> expenses, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

<p><b>Will you pay less if you use a <u>network provider</u>?</b></p>	<p>Yes. See <a href="http://www.allmyhealth.com">www.allmyhealth.com</a> or call 844-946-6236 for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>).</p> <p>Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p><b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b></p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All **copayment** and **coinsurance** costs shown in this chart are after your overall **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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.  Please refer to your <u>preventive</u> schedule for additional information.
	<u>Specialist</u> visit	No charge	50% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply.	No coverage for <u>preventive care</u> visits 50% <u>coinsurance</u> for <u>screening</u> services 50% <u>coinsurance</u> for immunizations	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	50% <u>coinsurance</u>	Precertification may be required.
	<u>Imaging</u> (CT/PET scans, MRIs)	No charge	50% <u>coinsurance</u>	Precertification may be required.

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 <b><u>prescription drug coverage</u></b> is available at <a href="http://www.allmyhealth.com">www.allmyhealth.com</a> .	Generic drugs	No charge (retail) No charge (mail order)	50% <u>coinsurance</u>	Up to 31-day supply retail pharmacy. Up to 93-day supply maintenance <u>prescription drugs</u> through mail order.  <u>Specialty drugs</u> are limited to a 31-day supply.  <u>Network</u> : insulin cost share will not exceed \$25 per retail prescription
	Brand drugs	No charge (retail) No charge (mail order)	50% <u>coinsurance</u>	
	Specialty drugs	No charge (retail) No charge (mail order)	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	50% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	No charge	50% <u>coinsurance</u>	Precertification may be required.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	No charge	No charge	Out-of- <u>network</u> : Subject to network deductible.
	<u>Emergency medical transportation</u>	No charge	No charge	Out-of- <u>network</u> : Subject to network deductible.
	<u>Urgent care</u>	No charge	No charge	Out-of- <u>network</u> : Subject to network deductible.
<b>If you have a hospital stay</b>	Facility fees (e.g., hospital room)	No charge	50% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	No charge	50% <u>coinsurance</u>	Precertification may be required.

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 mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge	50% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	No charge	50% <u>coinsurance</u>	Precertification may be required.
<b>If you are pregnant</b>	Office visits	No charge	50% <u>coinsurance</u>	<p>Cost sharing does not apply for <u>preventive services</u>.</p> <p>Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u>, or <u>deductible</u> may apply.</p> <p>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</p> <p><u>Network</u>: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive</u> Schedule for additional information.</p> <p>Precertification may be required.</p>
	Childbirth/delivery professional services	No charge	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge	50% <u>coinsurance</u>	

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	<u>Home health care</u>	No charge	50% <u>coinsurance</u>	<u>Network</u> : 120 visits per benefit period, combined with visiting nurse. <u>Out-of-network</u> : 60 visits per benefit period, combined with visiting nurse. Precertification may be required.
	<u>Rehabilitation services</u>	No charge	50% <u>coinsurance</u>	<u>Out-of-network</u> : 20 combined physical medicine and occupational therapy visits, and 20 speech therapy visits per benefit period. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse. Precertification may be required.
	<u>Habilitation services</u>	Not covered	Not covered	-----none-----
	<u>Skilled nursing care</u>	No charge	50% <u>coinsurance</u>	Combined <u>network</u> and <u>out-of-network</u> : 120 days per benefit period. Precertification may be required.
	<u>Durable medical equipment</u>	No charge	50% <u>coinsurance</u>	Precertification may be required.
	<u>Hospice services</u>	No charge	50% <u>coinsurance</u>	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	No charge <u>Deductible</u> does not apply.	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Private-duty nursing
- 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.)

- Acupuncture
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)

**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](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <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:

- Your plan administrator/employer.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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.

————— *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 \$6,350
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

**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>\$12,700</b>
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**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$6,350
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

<b>What isn't covered</b>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,410</b>

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

- The plan's overall deductible \$6,350
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

**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>\$5,600</b>
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**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

<b>What isn't covered</b>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,420</b>

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

- The plan's overall deductible \$6,350
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

**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:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

<b>What isn't covered</b>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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: \_\_\_\_\_.

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

