The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows how you and the plan would share the cost for covered health care services. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage call 1-800-348-6515 ext. 12. 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.dol.gov/ebsa/healthreform or call 1-800-348-6515 ext. 12 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Medical $250 person / $500 family Rx $100 person / $200 family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. 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 co-payment or co-insurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for the cost of covered services.
What is the out-of-pocket limit for this plan?	$3,000 person / $6,000 family PPO and NON-PPO combined.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Co-payments, deductibles, penalties, premiums, balanced-billed charges (unless balanced billing is prohibited) and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See http://provider.bcbs.com or call 1-800-348-6515, ext. 12 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 permission from this plan.

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 co-pay/visit	30% co-insurance	Deductible waived for PPO. Limited to one visit/day/qualified practitioner.
	Specialist visit	$20 co-pay/visit	30% co-insurance	Deductible waived for PPO. Limited to one visit/day/qualified practitioner.
	Preventive care/screening/ Immunization	No charge for initial Mammogram, Colonoscopy, PSA, PAP Calendar Year.	30% co-insurance	Deductible waived for PPO.
		What You Will Pay		

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance	30% co-insurance	None
	Imaging (CT/PET scans, MRIs)	$100 co-pay/day, 10% co-insurance	$100 co-pay/day, 30% co-insurance	Prior authorization required or benefit reduces by $250/occurrence. $100 co-pay does not apply to a free-standing imaging center.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envisionrx.com	Generic drugs	$10 co-pay or 20%: whichever is greater	$10 co-pay or 20%: whichever is greater	Annual deductible of $100 individual or $200 per family.
	Brand Prescription drugs	$10 co-pay or 20%: whichever is greater	$10 co-pay or 20%: whichever is greater	Annual deductible of $100 individual or $200 per family.
	Brand Prescription drugs with a generic available.	$10 co-pay or 20%: whichever is greater; plus the difference between the brand and the generic.	$10 co-pay or 20%: whichever is greater; plus the difference between the brand and the generic.	Annual deductible of $100 individual or $200 per family.
	Specialty drugs	10% co-pay	10% co-pay 10% co-pay	Deductible $250 individual / $500 – family. Max out-of-pocket $3,000 individual / $6,000 – family. *Prior authorization is required or no benefit is payable.*
		What You Will Pay		

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 co-pay/day, 10% co-insurance	$100 co-pay/day, 30% co-insurance	Prior authorization required or benefit reduces by $250/occurrence. $100 co-pay does not apply to an Ambulatory Surgery Center.
	Physician/surgeon fees	10% co-insurance	30% co-insurance	None
If you need immediate medical attention	Emergency room care	$60 co-pay/visit, 10% co-insurance	$60 co-pay/visit, 10% co-insurance	Non-PPO paid at PPO benefit level.
	Emergency medical transportation	10% co-insurance	10% co-insurance	Non-PPO paid at PPO benefit level.
	Urgent care	$40 co-pay/visit, 10% co-insurance	30% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 co-pay/ confinement, 10% co-insurance	$300 co-pay/confinement, 30% co-insurance	Deductible waived for PPO/Non-PPO. Prior authorization required or benefit reduces by $250/occurrence.
	Physician/surgeon fees	10% co-insurance	30% co-insurance	Deductible waived for PPO/Non-PPO.
Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information

If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 co-pay/visit, 10% co-insurance	30% co-insurance	
	Inpatient services	$300 co-pay/confinement, 10% co-insurance	$300 co-pay/confinement, 30% co-insurance	Deductible waived for PPO/Non-PPO. Prior authorization required or benefit reduces by $250/occurrence.
If you are pregnant	Office visits	$20 co-pay/visit	30% co-insurance	Deductible waived for PPO. Limited to one visit/day/qualified practitioner.
	Childbirth/delivery professional services	10% co-insurance	30% co-insurance	
	Childbirth/delivery facility services	$300 co-pay/confinement, 10% co-insurance	$300 co-pay/confinement, 30% co-insurance	Deductible waived for PPO/Non-PPO.
Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information

If you need help recovering or have other special health needs	Home health care	10% co-insurance	30% co-insurance	Limited to 60 visits/calendar year. Prior authorization required or benefit reduces by $250/occurrence.
	Rehabilitation services	$20 co-pay/visit, 10% co-insurance	30% co-insurance	Limited to a combined maximum of 60 visits/calendar year for Physical, Speech, and Occupational Therapy. Prior authorization required or benefit reduces by $250/occurrence.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	$300 co-pay/confinement, 10% co-insurance	$300 co-pay/confinement, 30% co-insurance	Deductible waived for PPO/Non-PPO. Limited to 90 days/sickness or injury. Prior authorization required or benefit reduces by $250/occurrence.
	Durable medical equipment	10% co-insurance	30% co-insurance	Prior authorization required or benefit reduces by $250/occurrence.
	Hospice services	10% co-insurance	30% co-insurance	Prior authorization required or benefit reduces by $250/occurrence.
If you or your child needs dental or eye care	Eye exam/glasses	Any amount in excess of what Plan will pay	Any amount in excess of what Plan will pay	Plan will pay $180 per person per calendar year. Maximum accumulation of $360 every 2 calendar years.
	Lasik	Any amount in excess of what Plan will pay	Any amount in excess of what Plan will pay	Plan will pay $600 per person per lifetime.
	Dental Services	Any amount in excess of what Plan will pay	Any amount in excess of what Plan will pay	Plan will pay 100% of first $500, 50% of next $3,000. Maximum of $2,000 per person/per calendar year.

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.)		
• Weight loss programs • Cosmetic surgery	• Habilitation services • Long-term care	• Private-duty Nursing

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 • Non-Emergency Care when traveling outside the U.S.	• Infertility treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You can 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, or the U.S. Department of Health and Human Services at 1-877-267-2323, ext. 61565. 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 the AMO Plan Office at 1-800-348-6515, ext. 12.

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 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: - 1-800-348-6515, ext. 12
Spanish (Español): Para obtener asistencia en Español, llame al
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
Chinese (中文): 如果需要中文的帮助, **请拨打这个号码**
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

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	$250
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$7,540

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$320
Coinsurance	$697
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$1,267

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

The plan's overall deductible	*$350
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$5,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	*$350
Copayments	**$120
Coinsurance	$773
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,243

** includes $100 deductible under Rx Plan*
*** assumes six office visits*

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

The plan's overall deductible	$250
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$2,540

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$200
Coinsurance	$209
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$659

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

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	Medical $300 person / $600 family Rx $100 person / $200 family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. 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 co-payment or co-insurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	None. $0 person/ $0 family	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no out-of-pocket limit.	Not applicable because there's no out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See http://provider.bcbs.com or call 1-800-348-6515, ext. 12 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 permission from this plan.

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 co-pay/visit	40% co-insurance	Deductible waived for PPO. Limited to one visit/day/qualified practitioner.
	Specialist visit	$20 co-pay/visit	40% co-insurance	Deductible waived for PPO. Limited to one visit/day/qualified practitioner.
	Preventive care/screening/ immunization	No Charge for initial Mammogram, Colonoscopy, PSA, PAP during Calendar Year	40% co-insurance	Deductible waived for PPO.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	None
	Imaging (CT/PET scans, MRIs)	$200 co-pay/day, 20% co-insurance	$200 co-pay/day, 40% co-insurance	Prior authorization required or benefit reduces by $250/occurrence. $200 co-pay does not apply to a free-standing imaging center.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envisionrx.com	Generic drugs	$10 co-pay or 20%: whichever is greater	$10 co-pay or 20%: whichever is greater	Annual deductible of $100 - individual or $200 per family.
	Brand Prescription Drugs	$10 co-pay or 20%: whichever is greater	$10 co-pay or 20%: whichever is greater	Annual deductible of $100 - individual or $200 per family.
	Brand Prescription Drugs with a generic available.	$10 co-pay or 20%: whichever is greater; plus the difference between the brand and the generic.	$10 co-pay or 20%: whichever is greater; plus the difference between the brand and the generic.	Annual deductible of $100 - individual or $200 per family.
	Specialty drugs	20% co-pay	20% co-pay	Annual deductible of $300 – individual or $600 per family. No maximum out-of-pocket. *Prior authorization is required or no benefit is payable.*

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 co-pay/day 20% co-insurance	$200 co-pay/day 40% co-insurance	Prior authorization required or benefit reduces by $250/occurrence. $200 co-pay does not apply to an Ambulatory Surgery Center.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	None
If you need immediate medical attention	Emergency room care	$60 co-pay/visit, 20% co-insurance	$60 co-pay/visit, 20% co-insurance	Non-PPO paid at PPO benefit level.
	Emergency medical transportation	20% co-insurance	20% co-insurance	Non-PPO paid at PPO benefit level.
	Urgent care	$40 co-pay/visit, 20% co-insurance	40% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 co-pay/ confinement, 20% co-insurance	$500 co-pay/ confinement, 40% co-insurance	Deductible waived for PPO/Non-PPO. Prior authorization required or benefit reduces by $250/occurrence.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Deductible waived for PPO/Non-PPO.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 co-pay/visit, 20% co-insurance	40% co-insurance	
	Inpatient services	$500 co-pay/confinement, 20% co-insurance	$500 co-pay/confinement, 40% co-insurance	Deductible waived for PPO/Non-PPO. Prior authorization required or benefit reduces by $250/occurrence.
If you are pregnant	Office visits	$20 co-pay/visit	40% co-insurance	Deductible waived for PPO. Limited to one visit/day/qualified practitioner.
	Childbirth/delivery professional services	20% co-insurance	40% co-insurance	Deductible waived for PPO/Non-PPO.
	Childbirth/delivery facility services	$500 co-pay/confinement, 20% co-insurance	$500 co-pay/confinement, 40% co-insurance	Deductible waived for PPO/Non-PPO.

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% co-insurance	40% co-insurance	Limited to 60 visits/calendar year. Prior authorization required or benefit reduces by $250/occurrence.
	Rehabilitation services	$20 co-pay/visit, 20% co-insurance	40% co-insurance	Limited to a combined maximum of 60 visits/calendar year for Physical, Speech, and Occupational Therapy. Prior authorization required or benefit reduces by $250/occurrence.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	$500 co-pay/confinement, 20% co-insurance	$500 co-pay/confinement, 40% co-insurance	Deductible waived for PPO/Non-PPO. Limited to 90 days/sickness or injury. Prior authorization required or benefit reduces by $250/occurrence.
	Durable medical equipment	20% co-insurance	40% co-insurance	Prior authorization required or benefit reduces by $250/occurrence.
	Hospice services	20% co-insurance	40% co-insurance	Prior authorization required or benefit reduces by $250/occurrence.
If you or your child needs dental or eye care	Eye exam/glasses	Any amount in excess of what Plan will pay	Any amount in excess of what Plan will pay	Plan will pay $120 per person per calendar year. Maximum accumulation of $240 every 2 calendar years.
	Lasik	Any amount in excess of what Plan will pay	Any amount in excess of what Plan will pay	Plan will pay $600 per person per lifetime.
	Dental Services	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.)		
• Weight loss programs • Cosmetic surgery	• Habilitation services • Long-term care	• Private-duty Nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic care	• Non-Emergency Care when traveling outside the U.S.	• Infertility treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You can 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, or the U.S. Department of Health and Human Services at 1-877-267-2323, ext. 61565. 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 the AMO Plans Office at 1-800-348-6515, ext.12.

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 the Minimum Value Standards? No
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: 1-800-348-6515, ext. 12
Spanish (Español): Para obtener asistencia en Español, llame al
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$300
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$7,540

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$520
Coinsurance	$1,344
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,164

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

The plan's overall deductible	*$400
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$5,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	**$120
Coinsurance	$976
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,496

**includes $100 deductible under Rx Plan*
***assumes six office visits*

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$2,540

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$200
Coinsurance	$408
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$908

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows how you and the plan would share the cost for covered health care services. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage call 1-800-348-6515 ext.12. 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.dol.gov/ebsa/healthreform or call 1-800-348-6515 ext. 12 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Medical $300 person / $600 family Rx $100 person / $200 family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. 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 co-payment or co-insurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	None. $0 person/ $0 family	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no out-of-pocket limit.	Not applicable because there's no out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See http://provider.bcbs.com or call 1-800-348-6515, ext. 12 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 permission from this plan.

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 co-pay/visit	40% co-insurance	Deductible waived for PPO. Limited to one visit/day/qualified practitioner.
	Specialist visit	$20 co-pay/visit	40% co-insurance	Deductible waived for PPO. Limited to one visit/day/qualified practitioner.
	Preventive care/screening/ immunization	No Charge for initial Mammogram, Colonoscopy, PSA, PAP during Calendar Year	40% co-insurance	Deductible waived for PPO.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	None
	Imaging (CT/PET scans, MRIs)	$200 co-pay/day, 20% co-insurance	$200 co-pay/day, 40% co-insurance	Prior authorization required or benefit reduces by $250/occurrence. $200 co-pay does not apply to a free-standing imaging center.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envisionrx.com	Generic drugs	$10 co-pay or 20%: whichever is greater	$10 co-pay or 20%: whichever is greater	Annual deductible of $100 - individual or $200 per family.
	Brand Prescription Drugs	$10 co-pay or 20%: whichever is greater	$10 co-pay or 20%: whichever is greater	Annual deductible of $100 - individual or $200 per family.
	Brand Prescription Drugs with a generic available.	$10 co-pay or 20%: whichever is greater; plus the difference between the brand and the generic.	$10 co-pay or 20%: whichever is greater; plus the difference between the brand and the generic.	Annual deductible of $100 - individual or $200 per family.
	Specialty drugs	20% co-pay	20% co-pay	Annual deductible of $300 – individual or $600 per family. No maximum out-of-pocket. *Prior authorization is required or no benefit is payable.*
	Services You May Need	What You Will Pay		

Common Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 co-pay/day 20% co-insurance	$200 co-pay/day 40% co-insurance	Prior authorization required or benefit reduces by $250/occurrence. $200 co-pay does not apply to an Ambulatory Surgery Center.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	None
If you need immediate medical attention	Emergency room care	$60 co-pay/visit, 20% co-insurance	$60 co-pay/visit, 20% co-insurance	Non-PPO paid at PPO benefit level.
	Emergency medical transportation	20% co-insurance	20% co-insurance	Non-PPO paid at PPO benefit level.
	Urgent care	$40 co-pay/visit, 20% co-insurance	40% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 co-pay/ confinement, 20% co-insurance	$500 co-pay/ confinement, 40% co-insurance	Deductible waived for PPO/Non-PPO. Prior authorization required or benefit reduces by $250/occurrence.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Deductible waived for PPO/Non-PPO.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 co-pay/visit, 20% co-insurance	40% co-insurance	
	Inpatient services	$500 co-pay/confinement, 20% co-insurance	$500 co-pay/confinement, 40% co-insurance	Deductible waived for PPO/Non-PPO. Prior authorization required or benefit reduces by $250/occurrence.
If you are pregnant	Office visits	$20 co-pay/visit	40% co-insurance	Deductible waived for PPO. Limited to one visit/day/qualified practitioner.
	Childbirth/delivery professional services	20% co-insurance	40% co-insurance	Deductible waived for PPO/Non-PPO.
	Childbirth/delivery facility services	$500 co-pay/confinement, 20% co-insurance	$500 co-pay/confinement, 40% co-insurance	Deductible waived for PPO/Non-PPO.
	Services You May Need	What You Will Pay		

Common Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Limited to 60 visits/calendar year. Prior authorization required or benefit reduces by $250/occurrence.
	Rehabilitation services	$20 co-pay/visit, 20% co-insurance	40% co-insurance	Limited to a combined maximum of 60 visits/calendar year for Physical, Speech, and Occupational Therapy. Prior authorization required or benefit reduces by $250/occurrence.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	$500 co-pay/confinement, 20% co-insurance	$500 co-pay/confinement, 40% co-insurance	Deductible waived for PPO/Non-PPO. Limited to 90 days/sickness or injury. Prior authorization required or benefit reduces by $250/occurrence.
	Durable medical equipment	20% co-insurance	40% co-insurance	Prior authorization required or benefit reduces by $250/occurrence.
	Hospice services	20% co-insurance	40% co-insurance	Prior authorization required or benefit reduces by $250/occurrence.
If you or your child needs dental or eye care	Eye exam/glasses	Any amount in excess of what Plan will pay	Any amount in excess of what Plan will pay	Plan will pay $180 per person per calendar year. Maximum accumulation of $360 every 2 calendar years.
	Lasik	Any amount in excess of what Plan will pay	Any amount in excess of what Plan will pay	Plan will pay $600 per person per lifetime.
	Dental Services	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.)

- Weight loss programs
- Cosmetic surgery
- Habilitation services
- Long-term care
- Private-duty Nursing

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

- Acupuncture
- Chiropractic care
- Non-Emergency Care when traveling outside the U.S.
- Infertility treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You can 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, or the U.S. Department of Health and Human Services at 1-877-267-2323, ext. 61565. 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 the AMO Plans Office at 1-800-348-6515, ext.12.

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 the Minimum Value Standards? No
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: 1-800-348-6515, ext. 12
Spanish (Español): Para obtener asistencia en Español, llame al
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
Chinese (中文): 如果需要中文的帮助, **请拨打这个号码**
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

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	$300
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$7,540

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$520
Coinsurance	$1,344
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,164

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

The plan's overall deductible	*$400
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$5,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	**$120
Coinsurance	$976
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,496

**includes $100 deductible under Rx Plan*
***assumes six office visits*

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$2,540

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$200
Coinsurance	$408
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$908

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