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. 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 Prescription Drug Coverage **$100** person / **$200** family	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.** Preventive care and primary care services are covered before you meet your deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	**No**	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these 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 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?	Copayments, deductibles, penalties, premiums, balance billing charges (unless balance 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.
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 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	$25 copayment/visit	30% coinsurance	Deductible waived for PPO. Limited to one visit/day/qualified practitioner.
	Specialist visit	$25 copayment/visit	30% coinsurance	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% coinsurance	Deductible waived for PPO.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	$105 copayment/day, 10% coinsurance	$105 copayment/day, 30% coinsurance	Prior authorization is required or benefit reduces by $250/occurrence. $105 copayment 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.mysmithrx.com	Generic drugs	$15 copayment or 20%: whichever is greater	$15 copayment or 20%: whichever is greater	Annual deductible of $100 individual or $200 per family.
	Preferred brand drugs	$15 copayment or 20%: whichever is greater	$15 copayment or 20%: whichever is greater	Annual deductible of $100 individual or $200 per family.
	Non-preferred brand drugs	$15 copayment or 20%: whichever is greater; plus, the difference between the brand and the generic	$15 copayment or 20%: whichever is greater; plus, the difference between the brand and the generic	Annual deductible of $100 individual or $200 per family.

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)	
	Specialty drugs	10% copayment	10% copayment	Deductible $250 individual / $500 – family. Max out-of-pocket $3,000 individual / $6,000 – family. Prior authorization is required or no benefit is payable.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$105 copayment/day, 10% coinsurance	$105 copayment/day, 30% coinsurance	Prior authorization required or benefit reduces by $250/occurrence. $105 copayment does not apply to an Ambulatory Surgery Center.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None.
If you need immediate medical attention	Emergency room care	$65 copayment/visit, 10% coinsurance	$65 copayment/visit, 10% coinsurance	Non-PPO paid at PPO benefit level.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Non-PPO paid at PPO benefit level.
	Urgent care	$45 copayment/visit, 10% coinsurance	30% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$305 copayment/ confinement, 10% coinsurance	$305 copayment/confinement, 30% coinsurance	Deductible waived for PPO/Non-PPO. Prior authorization required or benefit reduces by $250/occurrence.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Deductible waived for PPO/Non-PPO.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment/visit, 10% coinsurance	30% coinsurance	Deductible waived for PPO/Non-PPO. Prior authorization required or benefit reduces by $250/occurrence.
	Inpatient services	$305 copayment /confinement, 10% coinsurance	$305 copayment /confinement, 30% coinsurance	Deductible waived for PPO/Non-PPO. Prior authorization required or benefit reduces by $250/occurrence.

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 are pregnant	Office visits	$25 copayment/visit	30% coinsurance	Deductible waived for PPO. Limited to one visit/day/qualified practitioner.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None.
	Childbirth/delivery facility services	$305 copayment /confinement 10% coinsurance	$305 copayment /confinement, 30% coinsurance	Deductible waived for PPO/Non-PPO.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Limited to 60 visits/calendar year. Prior authorization required or benefit reduces by $250/occurrence.
	Rehabilitation services	$25 copayment/visit, 10% coinsurance	30% coinsurance	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	$305 copayment /confinement, 10% coinsurance	$305 copayment /confinement, 30% coinsurance	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% coinsurance	30% coinsurance	Prior authorization required or benefit reduces by $250/occurrence.
	Hospice services	10% coinsurance	30% coinsurance	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 through Blue Vision Plus Plan	Any amount in excess of what plan will pay	In Network: Plan will pay in accordance with the Blue Vision Plus Plan. Out of Network: Plan will pay $180 per person per calendar year. Maximum accumulation of $360 every 2 calendar years.
	Dental services	Any amount in excess of what plan will pay through Blue Dental Plus Plan	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.

* For more information about limitations and exceptions, see the plan or policy document at www.amoplans.com.

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	• Habilitation services	• Private-duty Nursing
• Cosmetic surgery	• Long-term care	

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

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-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323, ext. 61565 or www.cciio.cms.gov. 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 AMO Plan Office at **1-800-348-6515, ext. 12.**

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: - 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	$330
Coinsurance	$696
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,276**

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

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	$150
Coinsurance	$770
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,270**

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	$240
Coinsurance	$205
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$695**

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

* For more information about limitations and exceptions, see the plan or policy document at www.amoplans.com.