This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbst.com or by calling 1-800-565-9140. Coverage documents are not available until after the effective date of your coverage, but you may obtain a sample at http://www.bcbst.com/samplepolicy/2015/LG . This sample may not match your benefits exactly, so you should review your coverage document once it is available.
Contributions made by you and/or your employer to health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement arrangements (HRAs) may help pay your deductible or other out-of-pocket expenses.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$500** person/**$1,000** family Out-of-network: **$1,000** person/**$2,000** family Doesn't apply to preventive care. Copays do not apply to the deductible.	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 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.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$1,500** person/**$3,000** family Out-of-network: **$3,000** person/**$6,000** family	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?	Premium, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. This plan uses Network P. For a list of **in-network providers**, see www.bcbst.com or call 1-800-565-9140.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

Questions: Call 1-800-565-9140 or visit us at www.bcbst.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-565-9140 to request a copy.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	50% co-insurance after deductible	Office surgery subject to deductible/coinsurance.
	Specialist visit	$25 co-pay/visit	50% co-insurance after deductible	Office surgery subject to deductible/coinsurance.
	Other practitioner office visit	$25 co-pay/visit for Chiropractor	$50 co-pay/visit for Chiropractor	Chiropractic visits limited to 60 visits per year.
	Preventive care/screening/immunization	No Charge	No Charge	none
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance - no deductible	50% co-insurance after deductible	none
	Imaging (CT/PET scans, MRIs)	20% co-insurance – no deductible	50% co-insurance after deductible	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need drugs to treat your illness or condition	Generic drugs	Retail Pharmacy: $10 Mail Order Copay: $20	Not Covered	The plan pays 100% after the annual out of pocket Maximum of $3,450 individual and $6,900 family is reached.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Preferred brand drugs	Retail Pharmacy: $30 Mail Order Copay: $60	Not Covered	Cost difference between brand and generic forms unless generic is not available or Physician indicates "dispense as written". The plan pays 100% after the annual out of pocket Maximum of $3,450 individual and $6,900 family is reached.
	Non-preferred brand drugs	Retail Pharmacy: $50 Mail Order Copay: $100	Not Covered	
	Self-Administered Specialty drugs	Generic: $10 Preferred Brand: $30 Non-Preferred: $50	Not Covered	Two prescription fills are allowed at a retail location. All others must be made through Orchard Specialty Pharmacy. The plan pays 100% after the annual out of pocket Maximum of $3,450 individual and $6,900 family is reached.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	50% co-insurance after deductible	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	20% co-insurance after deductible	50% co-insurance after deductible	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained.
If you need immediate medical attention	Emergency room services	$250 co-pay/visit	$250 co-pay/visit	Copay waived if patient is admitted.
	Emergency medical transportation	20% co-insurance after deductible	20% co-insurance after deductible	Must be medically necessary.
	Urgent care	$35 co-pay/visit	50% co-insurance after deductible	Urgent Care benefits are determined by place of service, such as physician's office or ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	50% co-insurance after deductible	Prior Authorization required. Your cost share may increase to 60% if not obtained.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Physician/surgeon fee	20% co-insurance after deductible	50% co-insurance after deductible	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay/visit	50% co-insurance after deductible	Prior Authorization required for electro-convulsive therapy (ECT).
	Mental/Behavioral health inpatient services	20% co-insurance after deductible	50% co-insurance after deductible	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Substance use disorder outpatient services	$20 co-pay/visit	50% co-insurance after deductible	Prior Authorization required for electro-convulsive therapy (ECT).
	Substance use disorder inpatient services	20% co-insurance after deductible	50% co-insurance after deductible	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you are pregnant	Prenatal and postnatal care	$20 co-pay/visit	50% co-insurance after deductible	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Delivery and all inpatient services	20% co-insurance after deductible; Physician – no charge	50% co-insurance after deductible	none
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	50% co-insurance after deductible	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Rehabilitation services	$25 co-pay/visit	$50 co-pay/visit for Occupational, Physical, Speech and Cardiac. Pulmonary is 50% after deductible.	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	Habilitation services	$25 co-pay/visit	$50 co-pay/visit for Occupational, Physical, Speech and Cardiac. Pulmonary is 50% after deductible.	
	Skilled nursing care	20% co-insurance after deductible	50% co-insurance after deductible	Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Durable medical equipment	20% co-insurance after deductible	50% co-insurance after deductible	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not obtained.
	Hospice service	20% co-insurance after deductible	50% co-insurance after deductible	Prior Authorization required for Inpatient Hospice. Your cost share may increase to 60% if not obtained.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	none
	Glasses	Not Covered	Not Covered	none
	Dental check-up	Not Covered	Not Covered	none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids for adults
- Long-term care
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care for non-diabetics
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids for children under 18
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-565-9140**. You may also 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 x61565** or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Your Plan at **1-800-565-9140** or **www.bcbst.com**.
- The Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-565-9140**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-565-9140**.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1-800-565-9140**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-565-9140**.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,840
- **Patient pays** $1,700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$0
Co-insurance	$1,000
Limits or exclusions	$200
Total	**$1,700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,500
- **Patient pays** $1,900

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$100
Co-insurance	$600
Limits or exclusions	$700
Total	**$1,900**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.