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.myblueelementok.com. 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 1-855-653-1572 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred Provider: $500/individual or $1,500/family per benefit period. Nonpreferred Provider: $500/individual or $1,500/family per benefit period.	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. Prescription drugs, emergency treatment in the emergency room and the following services by a preferred provider: Preventive care, urgent care, specialist, and primary care physician 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Preferred Provider: $2,000/individual or Unlimited/family per benefit period. Nonpreferred Provider: $5,000/individual or Unlimited/family per benefit period.	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?	Penalties for failure to obtain pre-certification for services, premiums, balance-billing charges, 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.myblueelementok.com or call 1-855-653-1572 for a list of network providers.	This plan uses a provider network. You will pay less if you use a preferred provider in the plan's network. You will pay the most if you use a nonpreferred 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 preferred provider might use an nonpreferred 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
		Preferred Provider (You will pay the least)	Nonpreferred 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 copayment/visit (deductible does not apply)	$20 copayment/visit (deductible does not apply)	None.
	Specialist visit	$20 copayment/visit (deductible does not apply)	$20 copayment/visit (deductible does not apply)	None.
	Preventive care/screening/immunization	0% coinsurance (deductible does not apply)	0% coinsurance (deductible does not apply)	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance (deductible does not apply)	0% coinsurance (deductible does not apply)	When billed in conjunction with an office visit, no charge after office visit copayment.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.clearscript.org or call 1-800-819-5479.	Generic drugs	The great of: Retail: $12 copayment/prescription (deductible does not apply) Mail order: $36 copayment/prescription (deductible does not apply) or 30% coinsurance	The greater of: Retail: $12 copayment/prescription (deductible does not apply) or 30% coinsurance	All non-participating prescriptions are subject to an additional 20% penalty. Copay or coinsurance applies to a 30-day supply Retail or 90 day supply Mail-Order prescription (participating pharmacy only) If you use a non-participating pharmacy, you must also pay the difference in cost between a participating and the non-participating pharmacy. If you purchase a brand name drug when a generic drug is available expenses will not be covered.
	Preferred drugs	The great of: Retail: $25 copayment/prescription (deductible does not apply) Mail order: $75 copayment/prescription (deductible does not apply) or 30% coinsurance	The great of: Retail: $25 copayment/prescription (deductible does not apply) or 30% coinsurance	
	Non-preferred drugs	The great of: Retail: $25 copayment/prescription (deductible does not apply) Mail order: $75 copayment/prescription (deductible does not apply) or 30% coinsurance	The great of: Retail: $25 copayment/prescription (deductible does not apply) or 30% coinsurance	
	Specialty drugs	The great of: 30% coinsurance or Retail: $25 copayment/prescription (deductible does not apply) Mail order: Not covered	The great of: 30% coinsurance or Retail: $25 copayment/prescription (deductible does not apply)	Specialty drugs require prior authorization and are limited to a 30-day supply per fill.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copayment then 20% coinsurance	$200 copayment then 50% coinsurance	Pre-certification is required for certain outpatient services. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	$100 copayment/visit then 20% coinsurance	preferred provider benefit applies	Copay waived if admitted.
	Emergency medical transportation	0% coinsurance (deductible does not apply)	0% coinsurance (deductible does not apply)	None.
	Urgent care	$20 copayment/visit (deductible does not apply)	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment/admission then 20% coinsurance	$250 copayment/admission then 50% coinsurance	Rehabilitation inpatient limited to 30 days per benefit period. Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $20 copayment/visit (deductible does not apply) Other Outpatient Services: 20% coinsurance	Office: $20 copayment/visit (deductible does not apply) Other Outpatient Services: 50% coinsurance	None.
	Inpatient services	$250 copayment/admission then 20% coinsurance	$250 copayment/admission then 50% coinsurance	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you are pregnant	Office visits	$20 copayment/visit (deductible does not apply)	$20 copayment/visit (deductible does not apply)	Dependent daughters are not covered for this benefit.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$250 copayment/admission then 20% coinsurance	$250 copayment/admission then 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Home health care visits limited to 30 visits per benefit period. Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
	Rehabilitation services	20% coinsurance	50% coinsurance	Outpatient: physical and occupational therapy combined limited to 25 visits per benefit period. Speech therapy is not covered. Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	$250 copayment/admission then 20% coinsurance	$250 copayment/admission then 50% coinsurance	Skilled nursing care limited to 30 days per benefit period. Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-certification is required for durable medical equipment over $2,500. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
	Hospice services	20% coinsurance	50% coinsurance	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- 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.)

- Chiropractic care
- Hearing aids (limited one per ear every 48 months up to age 18 only)
- Private-duty nursing (limited to 85 visits per benefit period)

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. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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 1-855-653-1572.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-855-653-1572.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-653-1572.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-855-653-1572 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-653-1572.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-653-1572.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-653-1572.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-855-653-1572.

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

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

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	$500
Specialist copayment	$20
Hospital (facility) copayment	$250
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	$500
Copayments	$300
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,160**

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

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) copayment	$250
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	$500
Copayments	$600
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,180**

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

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) copayment	$250
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$50
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$750**

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