



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, go to [www.bcbsglobalsolutions.com](http://www.bcbsglobalsolutions.com) or by calling 1-855-282-3517. 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 1-855-282-3517 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	Outside the U.S. – \$350 individual/ \$1,050 family. Inside the U.S., <a href="#">in Network</a> – \$350 individual/ \$1,050 family. Inside the U.S., <a href="#">Out of Network</a> - \$500 individual/ \$1,500 family.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Some <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Outside the U.S., \$6,500 individual/ \$13,000 family. Inside U.S., <a href="#">in Network</a> - \$6,500 individual/ \$13,000 family. Inside the U.S., <a href="#">Out of Network</a> - \$10,000 individual/ \$20,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bcbsglobalsolutions.com">www.bcbsglobalsolutions.com</a> or call 1-855-282-3517 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

**Questions:** Call 1-855-282-3517 or visit us at [www.bcbsglobalsolutions.com](http://www.bcbsglobalsolutions.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.bcbsglobalsolutions.com](http://www.bcbsglobalsolutions.com) or call 1-855-282-3517 to request a copy.



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
		Outside the U.S. Provider	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	No charge	\$30 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	No charge	\$40 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	20 visits per Policy Year for Chiropractic Care.
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	No charge; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (X-ray, blood work)	No charge	No charge	20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	No charge	No charge	20% <a href="#">coinsurance</a>	Utilization review may apply.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbsglobalsolutions.com">www.bcbsglobalsolutions.com</a>	Generic drugs	\$0 <a href="#">copay</a> / per prescription per 30-day supply, no <a href="#">deductible</a>	\$10 <a href="#">copay</a> / per prescription per 30-day supply, no <a href="#">deductible</a>	50% <a href="#">copay</a> / per prescription per 30-day supply	Up to a 180-day supply available at participating provider. Mail order prescriptions available. Non-participating mail order pharmacy not covered.  Drug utilization review may apply.
	Preferred Brand-name drugs	\$0 <a href="#">copay</a> / per prescription per 30-day supply, no <a href="#">deductible</a>	\$50 <a href="#">copay</a> / per prescription per 30-day supply, no <a href="#">deductible</a>	50% <a href="#">copay</a> / per prescription per 30-day supply	
	Non preferred – Brand-name drugs	\$0 <a href="#">copay</a> / per prescription per 30-day supply, no <a href="#">deductible</a>	\$75 <a href="#">copay</a> / per prescription per 30-day supply, no <a href="#">deductible</a>	50% <a href="#">copay</a> / per prescription per 30-day supply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	20% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	No charge	No charge	20% <a href="#">coinsurance</a>	None

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.bcbsglobalsolutions.com](http://www.bcbsglobalsolutions.com) or call 1-855-282-3517.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Outside the U.S. Provider	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge	\$250 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	No charge	\$30 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	The Emergency Room Copay is waived if the insured person is admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	20% <a href="#">coinsurance</a>	Utilization review may apply.
	Physician/surgeon fees	No charge	No charge	20% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$30 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	None
	Inpatient services	No charge	No charge	20% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	No charge	\$40 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	No charge	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	No charge	20% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Outside the U.S. Provider	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	No charge	20% <a href="#">coinsurance</a>	120 visits/Policy Year
	<a href="#">Rehabilitation services</a>	No charge	\$40 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	60 visits/Policy Year. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	No charge	\$40 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	No charge	No charge	20% <a href="#">coinsurance</a>	120 days/Policy Year
	<a href="#">Durable medical equipment</a>	No charge	No charge	20% <a href="#">coinsurance</a>	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	No charge	No charge	20% <a href="#">coinsurance</a>	Utilization review may apply.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered			Not covered
	Children's glasses	Not covered			Not covered
	Children's dental check-up	No charge			Limited to a combined \$1,500 per Policy Year for all dental care. Deductible does not apply.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Routine foot care</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult &amp; Children)</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Acupuncture (if prescribed for rehabilitation purposes)</li> <li>Bariatric surgery</li> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Coverage provided outside the United States. See <a href="http://www.bcbsglobalsolutions.com">www.bcbsglobalsolutions.com</a></li> <li>Dental care (Adult &amp; Children)</li> <li>Hearing aids (limitations apply)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing (limitations apply)</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.bcbsglobalsolutions.com](http://www.bcbsglobalsolutions.com) or call 1-855-282-3517.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the insurer at 1-855-282-3517. 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](http://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](http://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](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 on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For questions about your rights, this notice, or assistance, you can contact: Customer Service at 1-855-282-3517.

**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 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 1-855-282-3517.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-282-3517.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-282-3517.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-282-3517.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$350
■ <a href="#">Specialist cost sharing</a>	\$40
■ Hospital (facility) <a href="#">cost sharing</a>	0%
■ Other <a href="#">cost sharing</a>	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:

Cost Sharing	
<a href="#">Deductibles</a>	\$350
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$420</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$350
■ <a href="#">Specialist cost sharing</a>	\$40
■ Hospital (facility) <a href="#">cost sharing</a>	0%
■ Other <a href="#">cost sharing</a>	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:

Cost Sharing	
<a href="#">Deductibles</a>	\$350
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$870</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$350
■ <a href="#">Specialist cost sharing</a>	\$40
■ Hospital (facility) <a href="#">cost sharing</a>	0%
■ Other <a href="#">cost sharing</a>	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:

Cost Sharing	
<a href="#">Deductibles</a>	\$350
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$850</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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