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, call 1-877-313-1335. 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.healthcare.gov/sbc-glossary/.com or call 1-877-313-1335 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 individual $3,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-Network preventive care, and some services with a copay. Contact customer service.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	In Network $3,000/ individual or $9,000/family & Out of Network $6,000 / individual or $18,000 / family	The out of pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization.	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.blueshield.com/networkPPO or call 1-877-313-1335 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.

(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

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
		In Network Provider (You will pay the least)	Out of Network (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	$30 copay (ded waived)	40%	Teladoc $30 copay. Other telemedicine visits are paid under the appropriate benefit category (i.e., PCP, Specialist, etc.).
	Specialist visit	$30 copay (ded waived)	40%	Teladoc $30 copay. Other telemedicine visits are paid under the appropriate benefit category (i.e., PCP, Specialist, etc.).
	Preventive care/screening/ immunization	No Charge (ded waived)	40%	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20%	40%	None
	Imaging (CT/PET scans, MRIs)	20%	40%	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** call EmpiRX at 1-877-323-0599	Preferred Generic drugs	$20 copay retail $40 copay mail order		Non-Specialty retail and mail order up to a 90-day supply. Note: 30-day copays shown. Out of pocket combined with medical.
	Preferred Brand drugs (including Non-Preferred Generic)	$30 copay retail $60 copay mail order		Your prescription plan is administered by EmpiRX. Call 1-877-323-0599 for more information on your prescription benefits.
	Non-Preferred Brand drugs	$50 copay retail $100 copay mail order		Non-Formulary Brand is not covered.
	Specialty drugs	20% co insurance up to $100/prescription		30-day supply. Mandatory mail required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20%	40%	None
	Physician/surgeon fees	20%	40%	None
If you need immediate medical attention	Emergency room care	$150 copay plus 20%	$150 copay plus 20%	Deductible waived. Copay waived if admitted. OON non-emergent use is 40%
	Emergency medical transportation	$50 copay plus 20%	$50 copay plus 20%	Deductible waived
	Urgent care	$35 copay (ded waived)	40%	None
If you have a hospital	Facility fee (e.g., hospital room)	20%	40%	Pre-cert required. Unapproved days are not

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network (You will pay the most)	
stay				covered.
	Physician/surgeon fees	20%	40%	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay (ded waived)	40%	None
	Inpatient services	20%	40%	Pre-cert required. Unapproved days are not covered.
If you are pregnant	Office visits	$30 copay (no charge for prenatal visit); ded waived	40%	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20%	40%	
	Childbirth/delivery facility services	20%	40%	
If you need help recovering or have other special health needs	Home health care	20%	40%	100 visits max per calendar year. Pre-cert is required. Unapproved days are not covered.
	Rehabilitation services	20%	40%	Includes physical, speech, occupational, cardiac & pulmonary.
	Habilitation services	20%	40%	Limited to treatment of autism and developmental delays.
	Skilled nursing care	20%	40%	100 days per calendar year max. Pre-cert is required. Unapproved days are not covered.
	Durable medical equipment	20%	40%	None
	Hospice services	20%	40%	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Eye refraction is not covered (preventive exam only).
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	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.)

- Cosmetic surgery
- Dental Care (adult)
- Dental care (child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility / Fertility treatment (Limits apply. Call CS for more information)

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/heathreform. 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: 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.

The Plan and Plan Sponsor described in the Summary of Benefits and coverage comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan and Plan Sponsor do not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The Plan and Plan Sponsor:

- ➲ Provide free aids and services to people with disabilities to communicate effectively with us, such as:

* For more information about limitations and exceptions, see the plan or policy document at https://tpabenefits.keenan.com/

- Qualified sign language interpreters; and
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

➲ Provide free language services to people whose primary language is not English, such as:
- Qualified interpreters; and
- Information written in other languages.

If you need these services, contact the Civil Rights Coordinator named in your Benefits Guide.

If you believe that the Plan or Plan Sponsor has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator named in your Benefits Guide. Contact information of the Civil Rights Coordinator can be found in the Benefits Guide.

You can file a grievance by mail or in person or fax or email. If you need help filing a grievance contact the Civil Rights Coordinator named in the Benefits Guide.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Language Access Services:

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-313-1335

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-313-1335

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-313-1335

Tagalog - Filipino

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-313-1335

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화해 주십시오. 1-877-313-1335

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-877-313-1335

Persian

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. تماس بگیرید 1-877-313-1335.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните. 1-877-313-1335

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。まで、電話にてご連絡ください。1-877-313-1335

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

Punjabi

ਧਿਆਨ ਦਿਓ :ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ,ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।' ਤੇ ਕਾਲ ਕਰੋ। 1-877-313-1335

Mon-Khmer Cambodian

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-877-313-1335

Hmong

LUS CEEV: Yog tias koj hais lus mob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau1-877-313-1335

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। पर कॉल करें। 1-877-313-1335

Thai

เรียน :ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-313-1335

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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	$1000
Specialist coinsurance	$30
Hospital (facility) coinsurance	20%
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	$1000
Copayments	$0
Coinsurance	$2000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3060**

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

The plan's overall deductible	$1000
Specialist coinsurance	$30
Hospital (facility) coinsurance	20%
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	$120
Copayments	$1130
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1270**

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

The plan's overall deductible	$1000
Specialist coinsurance	$30
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$270
Coinsurance	$340
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1010**

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