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, visit www.cfablue.com or call **877-889-2478**. 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 or call **877-889-2478** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** for VHC providers; **$500** individual / **$1,000** employee plus spouse, child, or children / **$1,000** family for in-network providers; and **$2,000** individual / **$4,000** employee plus spouse, child, or children / **$4,000** family for out-of-network providers. Out-of-network costs do not apply to the in-network deductible and vice versa. Copayments, pre-certification penalties, and balance-billed charges don't count toward the deductible.	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. In-network, office visits, preventive care, outpatient or inpatient physician/surgeon fees, ambulance, urgent care, delivery, home health care, rehabilitation/habilitation therapies and durable medical equipment are covered before you meet your deductible. Out-of-network, inpatient facility services are covered before you meet your deductible. Emergency room or hospice 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. 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?	Yes. **$100** individual / **$300** family for prescription drug coverage (retail). There are no other specific deductibles.	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?	**$4,000** individual / **$8,000** employee plus spouse, child, or children / **$8,000** family for VHC providers; **$6,000** individual / **$12,000** employee plus spouse, child, or children / **$12,000** family for in-network providers; **$12,000** individual / **$24,000** employee plus spouse, child, children /	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.

For more information about limitations and exceptions, see plan or policy document at www.cfablue.com or call 877-889-2478
* After deductible.

Important Questions	Answers	Why This Matters:
	$24,000 family for out-of-network providers. Out-of-network costs do not apply to the in-network out-of-pocket limit, and vice versa.	
What is not included in the out-of-pocket limit?	Prescription drugs, pre-certification penalties, premiums, balance-billed 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.vhcphysiciangroup.com for Virginia Hospital Center providers and **www.cfablue.com** for in-network providers or call **1-877-889-2478** for a list of network providers.	You pay the least if you use a provider in Virginia Hospital Center. You pay more if you use a provider in the 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
		Virginia Hospital Center (VHC) (You will pay the least)	In-Network Provider	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	$10/visit for PCP $15/visit for OB/GYN; Same as any covered service for telemedicine (non-designated provider)	$25/visit for PCP $15/visit for OB/GYN; Deductible does not apply Same as any covered service for telemedicine (non-designated provider)	50% coinsurance * Same as any covered service for telemedicine (non-designated provider)	Primary care includes physicians in general practice, family practice, internal medicine, pediatrics, obstetrics/gynecology, or geriatrics; and nurse practitioners.

For more information about limitations and exceptions, see plan or policy document at www.cfablue.com or call 877-889-2478

* After deductible.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Virginia Hospital Center (VHC) (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
	Specialist visit	$25/visit	$45/visit Deductible does not apply	50% coinsurance *	——————none——————
	Preventive care/screening/ immunization	No charge	No charge Deductible does not apply	50% coinsurance *	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)	No charge	$50/visit then 30% coinsurance *	50% coinsurance *	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	$50/visit then 30% coinsurance *	50% coinsurance *	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Virginia Hospital Center (You will pay the least)	Out-of-Network 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.caremark.com	Generic drugs	$5/prescription * (retail) $10/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	**Deductible:** **$100** individual / **$300** family for prescription drugs (retail). Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription). If you purchase a brand name drug in lieu of a generic drug, your copayments may be higher, as described in the plan document. When received at an in-network pharmacy, no charge for over-the-counter drugs related to preventive care, or FDA-approved generic and over-the-counter contraceptive
	Preferred brand drugs	$45/prescription * (retail) $90/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	
	Non-preferred brand drugs	$65/prescription * (retail) $130/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	
	Specialty drugs	Applicable copayment	Applicable copayment, plus charges in excess of the allowed amount	

For more information about limitations and exceptions, see plan or policy document at www.cfablue.com or call 877-889-2478

* After deductible.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Virginia Hospital Center (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				methods for women (prescription required). **Out-of-Pocket Maximum:** **$2,150** individual / **$4,300** family

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Virginia Hospital Center (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	$50/admission then 30% coinsurance *	50% coinsurance *	——————none——————
	Physician/surgeon fees	No charge	No charge Deductible does not apply	50% coinsurance *	——————none——————
If you need immediate medical attention	Emergency room care	No charge	$50/visit Deductible does not apply	$50/visit Deductible does not apply	——————none——————
	Emergency medical transportation	Not applicable	30% coinsurance; Deductible does not apply	30% coinsurance *	——————none——————
	Urgent care	No charge	No charge Deductible does not apply	50% coinsurance *	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	$100/admission then 30% coinsurance *	$2,000/admission then 50% coinsurance Deductible does not apply	Pre-certification required. Failure to pre-certify will reduce covered charges by $1,000. Failure to request extension of original certification will result in denial of benefits for the remainder of the hospital stay.
	Physician/surgeon fees	No charge	No charge Deductible does not	50% coinsurance *	——————none——————

For more information about limitations and exceptions, see plan or policy document at www.cfablue.com or call 877-889-2478

* After deductible.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Virginia Hospital Center (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
			apply		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15/visit; No charge for other outpatient services; Not covered for intensive outpatient services	$15/visit; No charge for other outpatient services Deductible does not apply	50% coinsurance *	————————none————————
	Inpatient services	No charge	$100/admission then 30% coinsurance * 15% coinsurance Deductible does not apply for inpatient visit	$2,000/admission then 50% coinsurance Deductible does not apply 50% coinsurance * for residential treatment facility	Pre-certification required (penalty applies).
If you are pregnant	Office visits	$15/visit up to a maximum of 10 visits/pregnancy	$15/visit up to a maximum of 10 visits/pregnancy	50% coinsurance *	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance, or deductible 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 Deductible does not apply	50% coinsurance *	————————none————————
	Childbirth/delivery facility services	No charge	$100/admission then 30% coinsurance *	$2,000/admission then 50% coinsurance Deductible does not apply	Pre-certification is required for inpatient (penalty applies).

For more information about limitations and exceptions, see plan or policy document at www.cfablue.com or call 877-889-2478

* After deductible.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Virginia Hospital Center (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance Deductible does not apply	50% coinsurance *	Maximum 90 visits/year.
	Rehabilitation services	No charge	$45/visit, deductible does not apply for outpatient; $50/admission then 30% coinsurance * for inpatient and cardiac rehabilitation	50% coinsurance *	Maximum 52 visits/year combined for occupational, physical, and speech therapies. Maximum 90 visits/treatment plan for cardiac rehabilitation.
	Habilitation services	No charge	30% coinsurance; Deductible does not apply	50% coinsurance *	Covered for children under age 19. Maximum 52 visits/year.
	Skilled nursing care	No charge	$50/admission then 30% coinsurance *	50% coinsurance *	Maximum 90 days/year.
	Durable medical equipment	No charge	30% coinsurance; Deductible does not apply	50% coinsurance *	——————none——————
	Hospice services	No charge	No charge Deductible does not apply	No charge Deductible does not apply	Maximum 180 days/lifetime for inpatient and outpatient hospice. Maximum 5 visits/lifetime for family counseling. Maximum 2 days/lifetime for bereavement counseling.
If your child needs dental or eye care	Children's eye exam	No charge	No charge Deductible does not apply	No charge Deductible does not apply	Maximum two exams/year.
	Children's glasses	No charge	No charge Deductible does not	No charge Deductible does not	Coverage limited to two pairs of glasses or twelve boxes of

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Virginia Hospital Center (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
			apply	apply	contacts/year. Maximum $300/year for glasses and contacts.
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered under the medical plan.

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, unless restoring bodily function or correcting deformity resulting from non-cosmetic surgery, accidental injury, or congenital defect
- Dental care (adult & child), unless due to accidental injury
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S., if purpose of travel is to receive care
- 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 (maximum 52 visits/year)
- Bariatric surgery, for morbid obesity
- Chiropractic care (maximum 40 visits/year)
- Hearing aids (one hearing aid per hearing impaired ear every 24 months for children under age 19)
- Private-duty nursing, outpatient
- Routine eye care (adult - $300 annual maximum)

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 plan at **877-889-2478**. You may also contact your state insurance department, the U.S. Department of Labor, 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 the plan at **877-889-2478**. You may also contact your state insurance department, the U.S. Department of Labor, 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 **877-889-2478**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **877-889-2478**.

Chinese (中文): **如果需要中文的帮助**，请拨打这个号码 **877-889-2478**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **877-889-2478**.

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** **$200**
- **Specialist *copayment*** **$25**
- **Hospital (facility) *copay* and *coins*** **$50+15%**
- **Other *coinsurance*** **15%**

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	$10
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$10**

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

- **The plan's overall deductible** **$200**
- **Specialist *copayment*** **$25**
- **Hospital (facility) *copay* and *coins*** **$50+15%**
- **Other *coinsurance*** **15%**

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	$100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$500**

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

- **The plan's overall deductible** **$200**
- **Specialist *copayment*** **$25**
- **Hospital (facility) *copay* and *coins*** **$50+15%**
- **Other *coinsurance*** **15%**

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	$10
Copayments	$80
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$390**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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