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 1-833-803-4457 or visit us at www.myqccbluelink.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 1-833-803-4457 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred **$3,000** person / **$6,000** family, Non-Preferred **$3,000** person / **$6,000** family.	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. Well-child care, prenatal care, and preventive care	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?	For Preferred providers **$4,500** person / **$6,500** family, for Non-Preferred providers **$9,000** person / **$18,000** family.	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?	Premiums, balance-billed charges, deductible carryover, penalties, Non-Preferred transplant subscriber liabilities and health care this plan does not 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.myqccbluelink.com or call: 1-833-803-4457** for a list of **Preferred 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 don't need a referral to see a specialist.	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)	Non-Preferred 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% coinsurance	30% coinsurance	---None---
	Specialist visit	20% coinsurance	30% coinsurance	---None---
	Preventive care/screening/ immunization	No Charge	No Charge	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% coinsurance	30% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myqccbluelink.com	Generic drugs	20% coinsurance for retail and mail order or 90-dayRx	20% coinsurance for retail and mail order or 90-dayRx	---None---
	Preferred brand drugs	20% coinsurance for retail and mail order or 90-dayRx	20% coinsurance for retail and mail order or 90-dayRx	---None---
	Non-preferred drugs	20% coinsurance for retail and mail order or 90-dayRx	20% coinsurance for retail and mail order or 90-dayRx	---None---
	Specialty drugs	Refer to the applicable prescription drug cost sharing	Not Covered	---None---
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	---None---
	Physician/surgeon fees	20% coinsurance	30% coinsurance	---None---
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	---None---
	Emergency medical transportation	20% coinsurance	20% coinsurance	---None---
	Urgent care	20% coinsurance	30% coinsurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	---None---
	Physician/surgeon fees	20% coinsurance	30% coinsurance	---None---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	---None---
	Inpatient services	20% coinsurance	30% coinsurance	---None---
If you are pregnant	Office visits	No Charge	30% coinsurance	---None---
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	---None---
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	---None---
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	---None---
	Rehabilitation services	20% coinsurance	30% coinsurance	---None---
	Habilitation services	20% coinsurance	30% coinsurance	---None---
	Skilled nursing care	20% coinsurance	30% coinsurance	120 days per person per calendar year
	Durable medical equipment	20% coinsurance	30% coinsurance	---None---
	Hospice services	20% coinsurance	30% coinsurance	---None---
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	---None---
	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)
- Private-duty nursing
- Routine foot care
- Weight loss program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery (Preferred providers)
- Chiropractic care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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: 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 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: 1-833-803-4457 or www.myqccbluelink.com. You may also contact the 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**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services

BlueLink TPA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BlueLink TPA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BlueLink TPA:

- provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that BlueLink TPA 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 our Civil Rights Coordinator.

There are four ways to file a grievance directly with BlueLink TPA:

- by mail: BlueLink TPA,
  ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 833-803-4457 (TTY 711);
- by fax: 215-761-0920; or
- by email: BLCivilRightsCoordinator@qccbluelink.com.

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

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, DC 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 833-803-4457 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 833-803-4457 (TTY: 711). (Spanish)

注意：如果您說中文，您可以免費獲得語言協助服務。請致電833-803-4457。(Chinese)

LO LUS TSEEMCEEB: Yog koj hais lus Hmoob, yeej muaj kev pab txhais lus pub dawb rau koj. Hu rau 833-803-4457. (Hmong)

CHÚ Ý: Nếu bạn nói tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ, miễn phí, cho bạn. Gọi 833-803-4457. (Vietnamese)

FIIRO GAAR AH: Hadii aad ku hadasho af-soomaali, waxaad heleysaa adeegyada kaalmada luuqada, oo bilaash ah. Lahadal 833-803-4457. (Somali)

သတိပြုရန်- သင် အင်္ဂလိပ်ဘာသာစကားကို ပြောဆိုလျှင် ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများကို အခမဲ့ ရရှိနိုင်ပါသည်။ 833-803-4457 သို့ ဖုန်းခေါ်ဆိုပါ။ (Burmese)

ВНИМАНИЕ! Если Вы говорите по- русски, Вы можете получить бесплатные услуги языковой поддержки. Позвоните по телефону 833-803-4457. (Russian)

انتباه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، متوفرة لك، مجاناً. اتصل على الرقم 833-803-4457. (Arabic)

Xiyyeeffannaa: yoo affan Inglizii kandubbatuu, gargaarsa tajaajilaa afaan,, kafalitii mallee, sifii qobayyaa. 833-803-4457. Bilibilli. (Oromo)

ATTENTION : si vous parlez français, sachez que vous pouvez bénéficier de services d'assistance linguistique gratuits. Appelez le 833-803-4457. (French)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenz-Systeme zur Verfügung. Rufen Sie die 833-803-4457 an. (German)

ትኩረት፡ አማርኛ የሚናገሩ ከሆነ፣ ያለምንም ክፍያ የቋንቋ እገዛ አገልግሎት ይሰጣል። 833-803-4457 ላይ ይደውሉ (Amharic)

주의: 한국어로 말하실 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 833-803-4457로 전화하십시오. (Korean)

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ ພ້ອມໃຊ້ງານສຳລັບທ່ານ.ໂທ 833-803-4457. (Laotian)

PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong para sa wika nang walang bayad. Tumawag sa 833-803-4457. (Tagalog)

BAA ÁKONÍNÍZIN: Bilagáana bizaad bee yáníłti'go , saad bee áká anáʼálwo', t'áá jíík'e bee ná ahóót'i'. Koji' hólne' 833-803-4457 (Navajo)

សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ អាចមានផ្តល់ជូនអ្នក។ ហៅលេខ 833-803-4457 ។ (Khmer)

Wann du schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 833-803-4457. (Pennsylvania Dutch)

ATTENZIONE: Se parli Italiano, servizi di assistenza linguistica, gratuiti, sono a tua disposizione. Chiama il numero 833-803-4457. (Italian)

સાવધાન: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાય સેવાઓ, મફતમાં, તમારા માટે ઉપલબ્ધ છે. 833-803-4457 પર કૉલ કરો. (Gujarati)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z darmowych usług pomocy językowej. Zadzwoń na numer 833-803-4457. (Polish)

ATANSYON: Si ou pale kreyòl, gen sèvis èd ak lang disponib pou ou gratis. Rele 833-803-4457. (Creole)

ATENÇÃO: Se falar português, tem disponíveis serviços gratuitos de assistência nesta língua. Ligue para o 833-803-4457. (Portuguese)

注：英語以外の言語をご利用の方には無料の言語アシスタントサービスがございます。833-803-4457にお電話ください。(Japanese)

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات کمکی زبانی به صورت رایگان برای شما مهیا است. با شماره 833-803-4457 تماس بگیرید (Farsi)

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	$3,000
Specialist coinsurance	20%
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,560**

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

The plan's overall deductible	$3,000
Specialist coinsurance	20%
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,440
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,500**

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

The plan's overall deductible	$3,000
Specialist coinsurance	20%
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,540
Copayments	$0
Coinsurance	$390
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,930**

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