




Blue Standardized Silver EPO

Coverage For: Individual + Family Plan Type: EPO

 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 1-855-350-7437 or visit us at AlabamaBlue.com/bb/2025ste.pdf. 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 AlabamaBlue.org/sbcglossary or call 1-855-350-7437 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$5,000 / individual or \$10,000 / family in-network. | 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 preventive services , Tier 1 and Tier 2 drugs; rehabilitation , habilitation , some physician services and some pediatric dental 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? | No. | You don't have to meet deductible for specific services. |
| What is the out-of-pocket limit for this plan ? | For in-network \$8,000 individual / \$16,000 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 limits has been met. |
| What is not included in the out-of-pocket limit ? | All out-of-network cost sharing amounts (deductibles , copays and coinsurance), premiums , balance-billing charges, healthcare this plan doesn't cover and specialty drug coupon programs payments. Exceptions include out-of-network medical emergency services (including mental health and substance abuse) and out-of-network air ambulance services. | 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 AlabamaBlue.com or call 1-800-810-BLUE 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 ? | Yes. Some services require a referral . | This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist . |



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 |
|---|--|--|--|---|
| | | Network Provider (You will pay the least) | 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 | \$40 copay /visit Deductible does not apply | Not Covered | Members are required to designate a Primary Care Physician (PCP) within the Blue High Performance Network (BlueHPN); in Alabama, referral is required if services are not rendered by your Primary Care Physician (unless seeing an Urgent Care provider, Behavioral Health provider, or provider specializing in OB/GYN); precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available |
| | Specialist visit | \$80 copay /visit Deductible does not apply | Not Covered | Referral is required in Alabama (unless seeing an Urgent Care provider, Behavioral Health provider, or provider specializing in OB/GYN); precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available |
| | Preventive care/screening/immunization | No Charge Deductible does not apply | Not Covered | Please visit AlabamaBlue.com/PreventiveServices and AlabamaBlue.com/StandardACAPreventiveDrugList . You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check your plan benefits for coverage. In Alabama, you must receive these services by your BlueHPN physician or be referred by your BlueHPN physician (except services for immunizations rendered by a pharmacy in the Pharmacy Vaccine Network or services rendered by a provider specializing in OB/GYN). For a printed copy, please contact Customer Service at 1-855-350-7437. |
| If you have a test | Diagnostic test (x-ray, blood work) | 40% coinsurance | Not Covered | Benefits listed are physician services ; some diagnostic tests and imaging may require precertification; if no precertification is obtained, no benefits are available |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance | Not Covered | |

* For more information about limitations and exceptions, see the [plan](#) or policy document at [AlabamaBlue.com/bb/2025ste.pdf](#).

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|---|---|
| | | Network Provider (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 AlabamaBlue.com/2025StandardizedSourcePlusRx1DrugList | Tier 1 Drugs | \$20 copay (retail) \$50 copay (mail order) Deductible does not apply | Not Covered | Benefits listed are only available through the ValueONE Retail Network and the Home Delivery Network; precertification is required for some drugs; if precertification is not obtained, no benefits are available; covered insulin products may have lower patient responsibility; select generic specialty and biosimilar drugs on the Select Generic Specialty and Biosimilar Drug List will have lower member cost share |
| | Tier 2 Drugs | \$40 copay (retail) \$100 copay (mail order) Deductible does not apply | Not Covered | |
| | Tier 3 Drugs | \$80 copay (retail) \$200 copay (mail order) | Not Covered | |
| | Tier 4 Drugs | \$350 copay (retail) | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance | Not Covered | Precertification may be required; if no precertification is obtained, no benefits are available |
| | Physician/surgeon fees | 40% coinsurance | Not Covered | Referral is required in Alabama |
| If you need immediate medical attention | Emergency room care | Accident: 40% coinsurance Medical Emergency: 40% coinsurance | Accident: 40% coinsurance Medical Emergency: 40% coinsurance | Physician charges will apply |
| | Emergency medical transportation | 40% coinsurance | 40% coinsurance | None |
| | Urgent care | \$60 copay /visit Deductible does not apply | Not Covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 40% coinsurance | Not Covered | In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; member pays 60% coinsurance after the deductible ; precertification is required; if no precertification is obtained, no benefits are available |
| | Physician/surgeon fees | 40% coinsurance | Not Covered | Precertification is required; if no precertification is obtained, no benefits are available; referral is required |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$40 copay /visit Deductible does not apply | Not Covered | In Alabama, out-of-network facility benefits are only available for accidental injury or medical emergency; member pays 60% coinsurance ; precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization ; if no precertification is obtained, no benefits are available |
| | Inpatient services | 40% coinsurance | Not Covered | |

* For more information about limitations and exceptions, see the [plan](#) or policy document at [AlabamaBlue.com/bb/2025ste.pdf](#).

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Office visits | 40% coinsurance | Not Covered | <p>Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). In Alabama, out-of-network facility benefits are only available for accidental injury or medical emergency; member pays 60% coinsurance after deductible; precertification may be required for some inpatient services; if no precertification is obtained, no benefits are available</p> |
| | Childbirth/delivery professional services | 40% coinsurance | Not Covered | |
| | Childbirth/delivery facility services | 40% coinsurance | Not Covered | |
| If you need help recovering or have other special health needs | Home health care | 40% coinsurance | Not Covered | Benefits for home intrusion services are also available; precertification is required outside Alabama; if no precertification is obtained, no benefits are available; referral is required |
| | Rehabilitation services | \$40 copay /visit Deductible does not apply | Not Covered | 30 visits per member per calendar year; includes occupational, physical and speech therapy; children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational and speech therapy |
| | Habilitation services | \$40 copay /visit Deductible does not apply | Not Covered | 30 visits per member per calendar year; includes occupational, physical and speech therapy; children ages 0-18 with an autistic diagnosis are allowed unlimited visits for occupational and speech therapy |
| | Skilled nursing care | Not Covered | Not Covered | Not covered; member pays 100% |
| | Durable medical equipment | 40% coinsurance | Not Covered | Referral is required; precertification may be required; if no precertification is obtained, no benefits are available |
| | Hospice services | 40% coinsurance | Not Covered | Precertification is required outside Alabama; if no precertification is obtained, no benefits are available; referral is required |
| If your child needs dental or eye care | Children's eye exam | 40% coinsurance | Not Covered | Benefits include one eye exam (including refraction) each calendar year for members up to the end of the month in which the member turns 19; referral is required |
| | Children's glasses | 40% coinsurance | 40% coinsurance | Benefits include one pair of prescription glasses (lenses and frames) or contact lenses (limited to one 12-month supply) each calendar year for members up to the end of the month in which the member turns 19 |
| | Children's dental check-up | No Charge Deductible does not apply | Not Covered | Benefits include diagnostic and preventive services for members up to the end of the month in which the member turns 19; additional benefits available; limitations apply; patient responsibility may vary |

* For more information about limitations and exceptions, see the [plan](#) or policy document at [AlabamaBlue.com/bb/2025ste.pdf](#).

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](#).)

- Abortion (except when necessary to prevent a serious health risk to the woman or as required by applicable laws)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Skilled nursing 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 (limited to 15 visits per member per calendar year)
- Infertility treatment (Assisted Reproductive Technology not covered)
- Non-emergency care when traveling outside the U.S.

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 <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> or Blue Cross and Blue Shield of Alabama at 1-855-350-7437. 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: Alabama Department of Insurance at 1-334-269-3550 or Insdept@insurance.alabama.gov.

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? Not applicable

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](#).

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) | | Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|-----------------|---|----------------|--|----------------|
| ■ The plan's overall deductible | \$5,000 | ■ The plan's overall deductible | \$5,000 | ■ The plan's overall deductible | \$5,000 |
| ■ Specialist copayment | \$80 | ■ Specialist copayment | \$80 | ■ Specialist copayment | \$80 |
| ■ Hospital (facility) coinsurance | 40% | ■ Hospital (facility) coinsurance | 40% | ■ Hospital (facility) coinsurance | 40% |
| ■ Other copayment/coinsurance | \$40/40% | ■ Other copayment/coinsurance | \$40/40% | ■ Other copayment/coinsurance | \$40/40% |
| <p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p> | | <p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p> | | <p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic tests (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p> | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| <i>Cost Sharing</i> | | <i>Cost Sharing</i> | | <i>Cost Sharing</i> | |
| Deductibles | \$5,000 | Deductibles | \$300 | Deductibles | \$2,100 |
| Copayments | \$00 | Copayments | \$900 | Copayments | \$300 |
| Coinsurance | \$3,000 | Coinsurance | \$0 | Coinsurance | \$0 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$60 | Limits or exclusions | \$40 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$8,060 | The total Joe would pay is | \$1,240 | The total Mia would pay is | \$2,400 |

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: AlabamaBlue.com.

Language Assistance Services, Auxiliary Aids, Services and Notice of Nondiscrimination only apply to administrative services that Blue Cross and Blue Shield of Alabama provides to your employer.

Discrimination is Against the Law

Language Assistance Services, Auxiliary Aids Services and Notice of Nondiscrimination:

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides reasonable modifications and free appropriate auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 1557 Compliance Coordinator. If you believe that we have 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 in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance 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, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-216-3144 (TTY: 711) or call Customer Service.

Arabic: انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-216-3144 (الهاتف النصي: 711) أو الاتصال بخدمة العملاء.

Chinese: 请注意: 如果您说普通话, 我们可免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以易读格式向您提供信息。请拨打 1-855-216-3144 (TTY 用户请拨 711) 或致电客户服务部。

French: À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1 855 216 3144 (TTY : 711) ou contactez le service client.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie +1 855 216 3144 (Durchwahl: 711) oder den Kundendienst an.

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટેની યોગ્ય સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-216-3144 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કોલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें या ग्राहक सेवा को कॉल करें।

Japanese: ご案内: 日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-855-216-3144 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

Korean: 주의: 한국어(를) 하시면 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-855-216-3144(TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

Lao: ເອົາໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີເຊມັນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-216-3144 (TTY: 711) ຫຼື ໂທຫາຝ່າຍບໍລິການລູກຄ້າ.

Portuguese: ATENÇÃO: Se você falar português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-855-216-3144 (TTY: 711) ou ligue para o Atendimento ao Cliente.

Russian: ВНИМАНИЕ. Если ваш язык русский язык, к вашим услугам бесплатная языковая помощь. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-216-3144 (TTY: 711) или обратитесь в службу поддержки клиентов.

Spanish: ATENCIÓN: Si usted habla español, hay disponibles servicios gratuitos de asistencia lingüística. También hay disponibles, de forma gratuita, ayudas y servicios auxiliares adecuados para dar información en formatos accesibles. Llame al 1-855-216-3144 (TTY: 711) o llame a Servicio al cliente.

Tagalog: ATTENTION: Kung nagsasalita ka ng Tagalog, available sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin ang naaangkop na mga pantulong na tulong at serbisyo nang walang bayad para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-216-3144 (TTY: 711) o tumawag sa Serbisyo sa Customer.

Turkish: DİKKAT Konuşmanız durumunda Türkçe, ücretsiz dil yardımı hizmetlerinden yararlanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak sunulmaktadır. 1-855-216-3144 (TTY: 711) nolu telefonu veya Müşteri Hizmetlerini arayın.

Vietnamese: CHÚ Ý: Nếu quý vị nói tiếng việt thì dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Chúng tôi cũng có các hỗ trợ và dịch vụ phụ trợ miễn phí phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận. Vui lòng gọi số 1-855-216-3144 (TTY: 711) hoặc gọi Dịch Vụ Khách Hàng.