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 888.816.3096. 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 1.888.816.3096 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** Single/**$4,000** Family	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. **Preventive** care services, office visits, urgent care and emergency care and prescriptions	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?	**$6,850** Single/**$13,700** 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, health care this **plan** doesn't cover and supplemental riders. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the **out-of-pocket** limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your **out-of-pocket** maximums.	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.healthplan.org or call 1-888-816-3096	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	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have a referral 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	$20 **copay** per visit	Not covered	**Deductible** waived
	Specialist visit	$20 **copay** per visit	Not covered	**Deductible** waived
	Preventive care/screening/ immunization	No charge	Not covered	**Deductible** waived. You may have to pay for services that aren't **preventive**. Ask your provider if the services needed are **preventive**.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Preauthorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthplan.org	Generic drugs	34-day retail: $10 **copay** 90-day home delivery $25 **copay**	Not covered	**Deductible** waived. Covers up to a 90-day supply retail, 90-day supply home delivery
	Preferred brand drugs	34-day retail: $20 **copay** 90-day home delivery $50 **copay**	Not covered	**Deductible** waived, Covers up to 90-day supply retail, 90-day supply home delivery. Member responsible for cost difference between generic and non-preferred brand
	Non-preferred brand drugs	34-day retail: $50 **copay** 90-day home delivery $125 **copay**	Not covered	**Deductible** waived, Covers up to 90-day supply retail, 90-day supply home delivery. Member responsible for cost difference between generic and non-preferred brand
	Specialty drugs	30% or $300 whichever is less	Not covered	**Deductible** waived. Covers up to 31-day supply. Preauthorization required. Please see "Important Questions" regarding the plan's out-of-pocket limit.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	**Preauthorization** is required
	Physician/surgeon fees	No charge	Not covered	**Preauthorization** is required
If you need immediate medical attention	Emergency room care	$150 **copay** per visit	$150 **copay** per visit	**Deductible** waived. **Copay** waived if admitted Non-emergent visits are not covered.
	Emergency medical transportation	$25 **copay** per incident	$25 **copay** per incident	Non-emergency transport **preauthorization** required
	Urgent care	$35 **copay** per visit	$35 **copay** per visit	**Deductible** waived. **Copay** waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	**Preauthorization** required unless emergent admission
	Physician/surgeon fees	No charge	Not covered	**Preauthorization** required unless emergent admission
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 **copay** per visit	Not covered	**Deductible** waived office visit only, other care may include tests and services described elsewhere in the SBC (i.e., diagnostic testing)
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	$20 **copay** initial visit only	Not covered	**Deductible** waived office visit only, maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound or **preventive** services
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	**Preauthorization** required. Limited to 100 visits per Benefit Year
	Rehabilitation services	$0 **copay**/day	Not covered	**Preauthorization** required
	Habilitation services	$15 **copay** per visit for visits 1-20. Visits 21+ 50% **coinsurance**	Not covered	**Preauthorization** required

* For more information about limitations and exceptions, see the plan or policy document at www.healthplan.org

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)	
	Skilled nursing care	$25 **copay** per visit	Not covered	**Preauthorization** required, limited to 90 days per Benefit Year
	Durable medical equipment	No charge	Not covered	Equipment greater than $500 **preauthorization** required
	Hospice services	No charge	Not covered	**Preauthorization** required
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None unless supplemental rider is purchased.
	Children's glasses	Not covered	Not covered	None unless supplemental rider is purchased.
	Children's dental check-up	Not covered	Not covered	None unless supplemental rider is purchased.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye 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.)

- Chiropractic care
- Private-duty nursing

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: the Department of Health and Human Services at 1.877.267.2323 x61565 or 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 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: The Health Plan Appeals Coordinator at 1.888.816.3096.

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 1.855.577.7123.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.855.577.7123.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1.855.577.7123.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1.855.577.7123.

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** $2,000
- **Specialist *[copayment]*** $20
- **Hospital (facility) *[cost sharing]*** $0
- **Other *[cost sharing]*** $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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000.00
Copayments	$50.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$2,050.00**

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

- **The plan's overall deductible** $2,000
- **Specialist *[copayment]*** $20
- **Hospital (facility) *[cost sharing]*** $0
- **Other *[cost sharing]*** $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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000.00
Copayments	$820.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$2,820.00**

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

- **The plan's overall deductible** $2,000
- **Specialist *[copayment]*** $20
- **Hospital (facility) *[cost sharing]*** $0
- **Other *[cost sharing]*** $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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2000.00
Copayments	$90.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$2090.00**

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