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 1-855-703-1740. 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.cciio.cms.gov or call 1-855-703-1740 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers, **$5,000** per person and **$10,000** per family. For out-of-network providers, **$10,000** per person and **$20,000** per 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. Preventive care 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers, **$6,750** per person and **$13,500** per family. For out-of-network providers, **$15,000** per person and **$30,000** per 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, precertification penalties, balance-billed charges, & 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. For a list of Network providers <insert Provider Look-up Link>	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.

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
		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% coinsurance after deductible	50% coinsurance after deductible	PCP includes General Practitioner, Family Practitioner, Internist, OB-Gyn, & Pediatrician.
	Specialist visit	20% coinsurance after deductible	50% coinsurance after deductible	----------none----------
	Preventive care/screening/ immunization	No charge	50% coinsurance Deductible does not apply.	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 after deductible	50% coinsurance after deductible	Pre-Certification is required for Genetic Testing or penalty applies.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification is required for non-emergent imaging or penalty applies.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at <PBM Link>.	Generic drugs	20% coinsurance per prescription after deductible	Not Covered	Prior authorization may be required. Limited to a 30-day supply. A 90-day supply may be obtained from a mail order pharmacy for 2 times the copay for the 30-day supply.
	Preferred brand drugs	20% coinsurance per prescription after deductible	Not Covered	
	Non-preferred brand drugs	50% coinsurance per prescription after deductible	Not Covered	
	Specialty drugs	20% coinsurance per prescription after deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions
		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)	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification required on certain surgical procedures.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible		Non-emergent services are not covered.
	Emergency medical transportation	20% coinsurance after deductible	50% coinsurance after deductible	----------none----------
	Urgent care	20% coinsurance after deductible	50% coinsurance after deductible	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required on inpatient admissions or penalty applies.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required on inpatient admissions or penalty applies.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	----------none----------
	Inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required on inpatient admissions or penalty applies.
If you are pregnant	Office visits	20% coinsurance after deductible	No charge	Pre-certification required if stay exceeds 48 hours for vaginal delivery or 96 hours for c-section or penalty applies.
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions
		Network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	Benefits are limited to 60 visits per year. Pre-Certification is required or penalty applies.
	Rehabilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification is required on Inpatient services or penalty applies. Physical Therapy, Occupational Therapy, and Speech Therapy limited to 30 visits per Therapy per year.
	Habilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification is required on Inpatient services or penalty applies. Physical Therapy, Occupational Therapy, and Speech Therapy limited to 30 visits per Therapy per year.
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Maximum 60 days per year.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification required on certain services or penalty applies.
	Hospice services	20% coinsurance after deductible	50% coinsurance after deductible	Bereavement counseling services are included.
If your child needs dental or eye care	Children's eye exam	Not Covered		----------None----------
	Children's glasses	Not Covered		----------None----------
	Children's dental check-up	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.)

- Acupuncture except when used for anesthesia
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult or Child)
- Habilitation services
- Hearing aids except for children ages 15 and under
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult or Child)
- Routine foot care, and
- 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 (30 visits per year)
- Infertility treatment, limited to artificial insemination
- Long-term Care

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 Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA. Other options to continue coverage are 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 Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA.

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.

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	$5,000
Specialist copay	$0
Hospital (facility) copayment	20%
Other copay or coinsurance	$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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$400
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$5,420

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

The plan's overall deductible	$5,000
Specialist copay	$0
Hospital (facility) copayment	20%
Other copay or coinsurance	$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	$5,000
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$5,040

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

The plan's overall deductible	$5,000
Specialist copay	$0
Hospital (facility) copayment	20%
Other copay or coinsurance	$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	$2,770
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Mia would pay is	$2,800

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