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 1-866-868-4139. 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.dol.gov/ebsa/healthreform or call 1-866-868-4139 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 individual / $0 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Emergency care, urgent care, & prescription drugs; plus laboratory tests, xrays and complex imaging, preventive care and office visits 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?	$3,150 individual / $12,700 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, balance-billed charges, amounts over Reasonable and Appropriate fees, precertification penalties 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?	No	This plan does not use a provider network. You can receive covered services from any provider.
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. All **coinsurance** amounts are stated as a percentage of Reasonable and Appropriate Fees, as defined in the Plan Document and Summary Plan Description

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay; Deductible does not apply	——————none——————
	Specialist visit	$25 copay; Deductible does not apply	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. Chiropractic care is not covered.
	Preventive care/screening/ immunization	No Charge	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)	$50 copay/test; Deductible does not apply	Not covered if services provided in a hospital
	Imaging (CT/PET scans, MRIs)	$400 copay/procedure; Deductible does not apply	Pre-certification is required or benefits reduced 10%; Not covered if services provided in a hospital.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **1.866.475.0056**	Generic drugs	$15/prescription (retail) and $30/prescription (mail order); Deductible does not apply	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Prescription orders in excess of one refill must be obtained through the mail order option.
	Preferred brand drugs	$25/prescription (retail) and $50/prescription (mail order); Deductible does not apply	
	Non-preferred brand drugs	$75/prescription (retail) and $150/prescription (mail order); Deductible does not apply	
	Specialty drugs	Not covered	Not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered.

If you need immediate medical attention	Emergency room care	$400 copay; Deductible does not apply	The ER use for non-emergency is not covered.
	Emergency medical transportation	Not covered	Not covered
	Urgent care	$200 copay; Deductible does not apply	Services for Non-urgent care are not covered
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance, after a $500 copay; Deductible does not apply	Pre-certification is required or benefits reduced 10%; limited to 10 days per Calendar Year; Room and Board Only; other facility charges not covered
	Physician/surgeon fees	Not covered	Not covered
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay; Deductible does not apply	——————none——————
	Inpatient services	40% coinsurance, after a $500 copay; Deductible does not apply	Pre-certification is required or benefits reduced 10%; limited to 10 days per Calendar Year; Room and Board Only; all other facility charges not covered
If you are pregnant	Office visits	Cost sharing does not apply for preventive services. Prenatal visits at the intervals recommended; You pay $0 with no copay and no deductible if billed separately; You pay 60% of a global prenatal and delivery charge with no copay and no deductible; $25 copay/visit for outpatient postnatal care, Deductible does not apply.	Postnatal care covered as Specialist Office Visit
	Childbirth/delivery professional services	Not covered	Not covered
	Childbirth/delivery facility services	40% coinsurance, after a $500 copay; Deductible does not apply	Pre-certification is required or benefits reduced 10%; limited to 10 days per Calendar Year; Room and Board Only; all other facility charges not covered

If you need help recovering or have other special health needs	Home health care	Not covered	Not covered
	Rehabilitation services	Not covered	Not covered
	Habilitation services	Not covered	Not covered
	Skilled nursing care	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered
	Hospice services	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered
	Children's glasses	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered

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
- Behavioral Health
- Children's dental check-up
- Children's eye exam
- Children's glasses
- Chiropractic Care
- Cosmetic Surgery
- Dental care (Adult)
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the US
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Specialty drugs
- Weight Loss programs

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

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 Employee Benefit Security Administration at 1-866-444-EBSA (3271) 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: Department of Labor Employee Benefit Security Administration at 1-866-444-EBSA (3271) 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 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 **1-866-868-4139**

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-866-868-4139**

Chinese (中文): 如果需要中文的帮助，请拨打这个号码**1-866-868-4139**

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-866-868-4139**

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	$0
Specialist copayment	$25
Hospital (facility) copayment	$400
Other 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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$990
Coinsurance	$1,440
What isn't covered	
Limits or exclusions	$8,580
The total Peg would pay is	**$11,010**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$400
Other 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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,760
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,780
The total Joe would pay is	**$3,540**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) copayment	$400
Other 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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$125
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,040
The total Mia would pay is	**$1,165**

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