**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, [insert contact information]. 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 call 1-855-375-7125 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | network and out-of-network providers:<br>$5,000 Individual / $10,000 Family<br>Benefit Period: Per Plan year. | 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 meet the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care , Prescription Drug and Physician 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?** | network and out-of-network providers:<br>$7,000 Individual / $14,000 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-billing charges, penalties for failure to obtain Preauthorization, ,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. It is an open access plan. However, the plan does provide a physician network through the MultiPlan PHCS Practitioner and Ancillary Network. A list of network providers can be found at www.multiplan.com or call 1-888.342.7427. | This plan is an open access plan |
| **Do you need a referral to see a specialist?** | No | You can see a specialist you choose without a referral |

[* For more information about limitations and exceptions, contact 1-855-375-7125

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 | $35 co-pay/ visit; deductible doesn't apply | $35 co-pay/ visit; deductible doesn't apply | None |
| | Specialist visit | $65 co-pay/ visit; deductible doesn't apply | $65 co-pay/ visit; deductible doesn't apply | Chiropractic Care – Limit 25 visits per plan year |
| | 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) | Lab / Blood Work: $35 co-pay; deductible doesn't apply<br>X-Ray: $65 co-pay; deductible doesn't apply | | None |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance after deductible | | Preauthorization is required |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at 877-226-2378. | Generic drugs | $15 co-pay Retail<br>$30 co-pay Mail Order | Not Covered | All Tiers.<br><br>Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).<br><br>Deductible waived for Rx. |
| | Preferred brand drugs | $60 co-pay Retail<br>$120 co-pay Mail Order | Not Covered | |
| | Non-preferred brand drugs | $100 co-pay Retail<br>$200 co-pay Mail Order | Not Covered | |
| | Specialty drugs | $200 co-pay Retail<br>$400 co-pay Mail Order | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance after deductible | | Preauthorization is required |
| | Physician/surgeon fees | $65 co-pay/ visit; deductible doesn't apply | $65 co-pay/ visit; deductible doesn't apply | ----------None---------- |
| **If you need immediate medical attention** | Emergency room care | $500 co-pay; deductible doesn't apply | | co-pay is waived if admitted as inpatient from ER. All facilities are covered as in-network subject to meeting "emergency" criteria |
| | Emergency medical transportation | 30% coinsurance after deductible | | None |

[* For more information about limitations and exceptions, contact 1-855-375-7125

| 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) | |
| | Urgent care | $65 co-pay/ visit; deductible doesn't apply | $65 co-pay/ visit; deductible doesn't apply | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance after deductible | | Preauthorization is required |
| | Physician/surgeon fees | 30% coinsurance after deductible | | Preauthorization is required |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $65 co-pay; deductible doesn't apply | $65 co-pay; deductible doesn't apply | Preauthorization is required for intensive care outpatient service. Maximum 30 visits for ABA therapy per plan year. |
| | Inpatient services | 30% coinsurance after deductible | | Preauthorization is required |
| **If you are pregnant** | Office visits | $35 co-pay/ 1st Visit; deductible doesn't apply | $35 co-pay/ 1st Visit; deductible doesn't apply | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 30% coinsurance after deductible | 30% coinsurance after deductible | Preauthorization is required |
| | Childbirth/delivery facility services | 30% coinsurance after deductible | | Preauthorization is required |
| **If you need help recovering or have other special health needs** | Home health care | $65 co-pay/ Visit; deductible doesn't apply | $65 co-pay/ Visit; deductible doesn't apply | Preauthorization is required. Maximum 60 visits per plan year |
| | Rehabilitation services | $65 co-pay/ Visit; deductible doesn't apply | $65 co-pay/ Visit; deductible doesn't apply | Preauthorization is required. Maximum 30 visits per therapy per plan year. Includes physical therapy, speech therapy, and occupational therapy. |
| | Habilitation services | $65 co-pay/ Visit; deductible doesn't apply | $65 co-pay/ Visit; deductible doesn't apply | Preauthorization is required. Maximum 30 visits per plan year |
| | Skilled nursing care | 30% coinsurance after deductible | | Preauthorization is required. 60 day maximum per plan year. |
| | Durable medical equipment | 30% coinsurance after deductible | | Preauthorization is required |
| | Hospice services | 30% coinsurance after deductible | | Preauthorization is required |

| 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 your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | 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.)**

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Hearing Aids
- Long-Term Care
- Non-Emergency Care outside US
- Routine Dental Care
- 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
- Infertility Services (Basic)

**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: 1-866-444-3272 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: 1-855-375-7125.

**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.

**Language Access Services:**

[* For more information about limitations and exceptions, contact 1-855-375-7125

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-375-7125
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-375-7125.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-375-7125.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-375-7125.

*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 co-pay** **$65**
- **Hospital (facility) coinsurance** **30%**
- **Other co-insurance** **30%**

**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** | **$13,540** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,000 |
| Copayments | $265 |
| Coinsurance | $1,735 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$7,000** |

### 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 co-pay** **$65**
- **Hospital (facility) coinsurance** **30%**
- **Other co-insurance** **30%**

**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** | **$4,110** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,250 |
| Copayments | $340 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $290 |
| **The total Joe would pay is** | **$2,880** |

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

- **The plan's overall deductible** **$5,000**
- **Specialist co-pay** **$65**
- **Hospital (facility) coinsurance** **30%**
- **Other co-insurance** **30%**

**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** | **$2,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $900 |
| Copayments | $530 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,430** |

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