




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, 1-866-298-9848. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-866-298-9848 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$2,000 individual / \$4,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , primary care, <a href="#">specialist</a> visits, and <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$7,150 individual / \$14,300 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.multiplan.com">www.multiplan.com</a> or call 1-866-298-9848 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. This <a href="#">plan</a> does not utilize a <a href="#">network</a> for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply. Not covered if provided at hospital.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit	Not covered	<a href="#">Deductible</a> does not apply. Not covered if provided at hospital.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	<a href="#">Deductible</a> does not apply. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. Coverage limited to 1 visit per plan year and 1 immunization of each type.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 <a href="#">copay</a> /test	Not covered	Not covered if services are provided at hospital.
	Imaging (CT/PET scans, MRIs)	50% <a href="#">coinsurance</a> /test	Not covered	Not covered if services are provided at hospital. <a href="#">Preauthorization</a> is required. Failure to comply will result in claim denial and member will be responsible for 100% of claim.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> call 1-866-298-9848	Generic drugs	\$20 <a href="#">copay</a> /prescription	Not covered	<a href="#">Deductible</a> does not apply. Coverage limited to standard generics only.
	Preferred brand drugs	Not covered	Not covered	None
	Non-preferred brand drugs	Not covered	Not covered	None
	<a href="#">Specialty drugs</a>	Not covered	Not covered	Biotech is considered a specialty drug not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	None
	Physician/surgeon fees	Not covered	Not covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	Not covered	Not covered	None
	<a href="#">Emergency medical transportation</a>	Not covered	Not covered	None

\* For more information about limitations and exceptions, see the plan or policy document.

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)	
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a>	Not covered	Not covered if services are provided at hospital.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not covered	Not Covered	None
	Physician/surgeon fees	Not covered	Not covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$50 <a href="#">copay</a> / admission	Not covered	Coverage limited to outpatient services.
	Inpatient services	Not covered	Not Covered	None
<b>If you are pregnant</b>	Office visits	Not covered	Not covered	None
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not Covered	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not covered	Not covered	None
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copay</a> / therapy	Not covered	Combined limit for all rehabilitation and habilitation therapies of 20 visits per plan year.
	<a href="#">Habilitation services</a>	\$50 <a href="#">copay</a> / therapy	Not covered	
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	None
	<a href="#">Durable medical equipment</a>	Not covered	Not covered	
	<a href="#">Hospice services</a>	Not covered	Not covered	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	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       | • Hearing Aids                                       | • Private Duty Nursing     |
| • Bariatric Surgery | • Infertility Treatment                              | • Routine eye care (Adult) |
| • Chiropractic Care | • Long Term Care                                     | • Routine Foot Care        |
| • Cosmetic Surgery  | • Non-emergency care when traveling outside the U.S. | • Weight Loss Programs     |
| • Dental Care       |  |                            |

\* For more information about limitations and exceptions, see the plan or policy document.

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

- Only benefits explicitly listed.

**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 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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](http://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: 1-866-298-9848. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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? No.**

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 1-866-298-9848.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-298-9848

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-298-9848

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-866-298-9848

—————*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	NC
■ Other <a href="#">copayment</a>	N/A

#### 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$650
Coinsurance	\$4,500
<i>What isn't covered</i>	
Limits or exclusions	\$2,700
<b>The total Peg would pay is</b>	<b>\$9,850</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	NC
■ Other <a href="#">copayment</a>	\$15

#### 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,500
<b>The total Joe would pay is</b>	<b>\$3,900</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	NC
■ Other <a href="#">copayment</a>	N/A

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,400
<b>The total Mia would pay is</b>	<b>\$1,900</b>