⚠ 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 or call 1-866-298-9848 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0. | See the Common Medical Events chart below for your costs for services this plan covers. |
| **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?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | Yes. See www.multiplan.com or call 1-866-298-9848 for a list of network providers. | 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). |
| **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 (In-Network Provider) | 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 | $150 Copay New Doctor; $50 Copay Existing Doctor | Not covered if services are provided at hospital. Only covers in-network services; there is no coverage for out-of-network services. |
| | Specialist visit | $200 Copay New Doctor; $100 Copay Existing Doctor | |
| | Preventive care/screening/ immunization | 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. Only covers in-network services; there is no coverage for out-of-network services. |
| **If you have a test** | X-ray | $75 Copay Per X-Ray billed | Not covered if services are provided at hospital. Only covers in-network services; there is no coverage for out-of-network services. |
| | Lab | $50 Copay Per Panel Tested | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available by calling 1-866-298-9848. | Generic drugs | No charge | Limited to recommended preventive care as outlined by the Patient Protection & Affordable Care Act. |
| | Preferred brand drugs | Not covered | None |
| | Non-preferred brand drugs | Not covered | |
| | Specialty drugs | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not covered | None |
| | Physician/surgeon fees | Not covered | |
| **If you need immediate medical attention** | Emergency room care | Not covered | None |
| | Emergency medical transportation | Not covered | |
| | Urgent care | $150 Copay | Only covers in-network services; there is no coverage for out-of-network services. |

| Common Medical Event | Services You May Need | What You Will Pay (In-Network Provider) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not covered | None |
| | Physician/surgeon fees | Not covered | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Not covered | None |
| | Inpatient services | Not covered | |
| **If you are pregnant** | Office visits | Not covered | None |
| | Childbirth/delivery professional services | Not covered | |
| | Childbirth/delivery facility services | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | Not covered | None |
| | Rehabilitation services | Not covered | |
| | Habilitation services | Not covered | |
| | Skilled nursing care | Not covered | |
| | Durable medical equipment | Not covered | |
| | Hospice services | Not covered | |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | None |
| | Children's glasses | Not covered | |
| | Children's dental check-up | 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
- Chiropractic Care
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- 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.)**

- Only benefits explicitly listed in this Summary of Benefits and Coverage

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

**Does this plan provide Minimum Essential Coverage?  No.**
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:**
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, kwiijigo 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.

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### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The **plan's** overall **deductible**    $0
- **Specialist** copay    $200 or $100
- Hospital (facility) **coinsurance**    N/A
- Lab copay    $50

**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 | $0 |
| Copayments | $250 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $12,550 |
| **The total Peg would pay is** | **$12,550** |

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### 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** copay    $200 or $100
- Hospital (facility) **coinsurance**    N/A
- Lab copay    $50

**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 | $7,400 |
|---|---|

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

| Cost Sharing | |
|---|---|
| Deductibles | $0 |
| Copayments | $250 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $7,150 |
| **The total Joe would pay is** | **$7,150** |

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

- The **plan's** overall **deductible**    $0
- **Specialist** copay    $200 or $100
- Hospital (facility) **coinsurance**    N/A
- X-Ray    $75 Copay Per X-Ray billed

**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 | $1,900 |
|---|---|

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

| Cost Sharing | |
|---|---|
| Deductibles | $0 |
| Copayments | $275 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $1,625 |
| **The total Mia would pay is** | **$1,625** |

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