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 1.888.816.3096. 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 https://www.healthcare.gov/sbc-glossary or call 1.888.816.3096 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** Single/ **$2,000** 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. Office visits, prescriptions and preventive care.	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?	Medical/Hospital: **$3,000** Single/ **$6,000** Family Rx: **$4,100** Single/ **$8,200** Family Deductible does not apply to out-of-pocket maximum.	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 and healthcare 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. Call **1.888.816.3096** or visit www.healthplan.org for a list of participating 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**). 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, & 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	$20 copay/visit (deductible waived)	Not covered	None
	Specialist visit	$40 copay/visit (deductible waived)	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	25%, $10 min/retail; 20%, $5 min $25 max/mail order	Not covered	Deductible waived. Covers up to a 34-day supply retail; 90-day supply mail order. Member is responsible for cost difference between generic and brand drugs.
	Preferred brand drugs	25%, $10 min/retail; 20%, $5 min $25 max/mail order	Not covered	
	Non-preferred brand drugs	25%, $10 min/retail; 20%, $5 min $25 max/mail order	Not covered	
	Specialty drugs	20%, $5 min $25 max	Not covered	Covers up to a 34-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None

* For more information about limitations and exceptions, see your Benefits Office for a copy of the plan or policy document.

If you need immediate medical attention	Emergency room care	$300 copay/visit then 20% coinsurance	$300 copay/visit then 20% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit (deductible waived)	Not covered	Copay applies to office visit only.
	Inpatient services	20% coinsurance	Not covered	Copay applies to office visit only.
If you are pregnant	Office visits	$40 copay/visit (deductible waived)	Not covered	**Cost sharing** does not apply for **preventive services**.
	Childbirth/delivery professional services	20% coinsurance	Not covered	None
	Childbirth/delivery facility services	20% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Services for intermittent skilled care only.
	Rehabilitation services	20% coinsurance	Not covered	Occupational, physical and speech therapy limited to 20 visits/each per plan year.
	Habilitation services	20% coinsurance	Not covered	Occupational, physical and speech therapy limited to 20 visits/each per plan year.
	Skilled nursing care	20% coinsurance	Not covered	Limited to a maximum of 100 days per plan year.
	Durable medical equipment	20% coinsurance	Not covered	Limited to standard model only.
	Hospice services	20% coinsurance	Not covered	Life expectancy of six months or less.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Pediatric screening only.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	Pediatric screening only.

* For more information about limitations and exceptions, see your Benefits Office for a copy of the plan or policy document.

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
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs
- Routine eye care (Adult)

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

- Bariatric Surgery
- Chiropractic care
- Hearing aids
- Private-duty nursing

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 1.866.444.EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services at 1.877.267.2323 x61565 or www.cciio.cms.gov. 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: The Health Plan Appeals Coordinator at 1.888.816.3096 or the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) 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 certain types of 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 1.855.577.7123.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.855.577.7123.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1.855.577.7123.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1.855.577.7123.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see your Benefits Office for a copy of the plan or policy document.

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	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,100.00
Copayments	$0.00
Coinsurance	$1,900.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$3,000.00**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,100.00
Copayments	$120.00
Coinsurance	$310.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$1,340.00**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,100.00
Copayments	$130.00
Coinsurance	$110.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$1,340.00**

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