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, go to www.allwaysmember.org or by calling Customer Services at 1-866-414-5533 (toll free) or 711 (TTY). 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.allwayshealthpartners.org or call 1-866-414-5533 (toll free) or 711 (TTY) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-Network (IN): $2,000**/Individual, **$4,000**/Family per benefit period. **Out-of-Network (OON): $4,000**/Individual Policy, **$8,000**/Family per benefit period.	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 policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, most outpatient visits (including mental/behavioral health and substance use disorder), generic and preferred brand-name prescription drugs, and urgent care does not apply to the deductible.	This plan covers some items and services even if you haven't yet met the annual 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 www.allwayshealthpartners.org.
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?	**In-Network (IN): $8,150**/Individual, **$16,300**/Family per benefit period. **Out-of-Network (OON): $16,300**/Individual, **$32,600**/Family per benefit period.	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 family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, Out-of-Network penalties for failure to obtain prior authorization, Out-of-Network charges above the **allowed amount**, and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see www.allwayshealthpartners.org.	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 (a balance bill). 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	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	20% coinsurance after OON deductible	---none---
	Specialist visit	$60 copay/visit	20% coinsurance after OON deductible	---none---
	Preventive care/ screening/immunization	No charge	20% coinsurance after OON deductible	Services for specific conditions during an annual exam may be subject to cost sharing.
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray $75 copay after IN deductible / Blood work $60 copay after IN deductible	20% coinsurance after OON deductible	---none---
	Imaging (CT/PET scans, MRIs)	$500 copay after IN deductible	20% coinsurance after OON deductible	May require prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available www.allwayshealthpartners.org.	Low-Cost Generic drugs	Retail: $5 copay Maintenance 90: $10 copay		No charge for birth control and smoking cessation drugs.
	Generic drugs	Retail: $30 copay Maintenance 90: $60 copay		
	Preferred brand drugs	Retail: $60 copay Maintenance 90: $120 copay		May require prior authorization.
	Non-preferred brand drugs	Retail: $100 copay after IN deductible Maintenance 90: $300 copay after IN deductible		May require prior authorization.
	Specialty drugs	Preferred brand-name: $60 copay Non-preferred brand-name: $100 copay after IN deductible		Prescription must be filled through our specialty pharmacy and a prior authorization may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider	Out-of-network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay/visit after IN deductible	20% coinsurance after OON deductible	May require prior authorization.
	Physician/surgeon fees	No charge after IN deductible	20% coinsurance after OON deductible	---none---
If you need immediate medical attention	Emergency room services	$350 copay/visit after IN deductible		Emergency room copay waived if admitted to hospital for inpatient care.
	Emergency medical transportation	No charge after IN deductible		---none---
	Urgent care	$60 copay/visit	20% coinsurance after OON deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room	$1,000 copay/admission after IN deductible	20% coinsurance after OON deductible	May require prior authorization.
	Physician/surgeon fee	No charge after IN deductible	20% coinsurance after OON deductible	---none---
If you need mental health, behavioral health, or substance use services	Mental/behavioral health/substance use outpatient services	$30 copay/visit	20% coinsurance after OON deductible	---none---
	Mental/behavioral health/substance use inpatient services	$1,000 copay/admission after IN deductible	20% coinsurance after OON deductible	May require prior authorization.
If you are pregnant	Office visits for prenatal and postnatal care	No charge for routine prenatal and postnatal care	20% coinsurance after OON deductible	---none---
	Childbirth/delivery facility services	$1,000 copay/admission after IN deductible	20% coinsurance after OON deductible	May require prior authorization.
	Childbirth/delivery professional services	No charge after IN deductible	20% coinsurance after OON deductible	May require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider	Out-of-network Provider	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance after OON deductible	May require prior authorization.
	Rehabilitation services	**Outpatient:** $60 copay/visit **Inpatient:** $1,000 copay/ admission after IN deductible	20% coinsurance after OON deductible	**Outpatient:** Covered up to 60 visits per benefit period for Physical Therapy/Occupational Therapy. **Inpatient**: Covered up to 60 days per benefit period. Prior authorization required.
	Habilitation services	**Outpatient:** $60 copay/visit **Inpatient:** $1,000 copay/ admission after IN deductible	20% coinsurance after OON deductible	**Outpatient:** Covered up to 60 visits per benefit period for Physical Therapy/Occupational Therapy. **Inpatient:** Covered up to 60 days per benefit period. Prior authorization required. Cost and coverage limits are waived for early intervention services for eligible children.
	Skilled nursing care	$1,000 copay/admission after IN deductible	20% coinsurance after OON deductible	Covered up to 100 days per benefit period. May require prior authorization.
	Durable medical equipment	20% coinsurance after IN deductible	20% coinsurance after OON deductible	May require prior authorization. No charge for electric breast pump (one per birth).
	Hospice service	No charge	20% coinsurance after OON deductible	May require prior authorization.
If your child needs dental or eye care	Children's eye exam	No charge		One eye exam every 12 months per child covered under this plan up to the age of 19.
	Children's glasses	No charge		Provider designated frames.
	Children's dental check-up	No charge		Limited to 2 exams every calendar year per child covered under this plan up to age 19.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care–adult (you may have coverage under a separate dental plan)
- Extraction of infected or impacted wisdom teeth (except when in a hospital setting)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Abortion
- Bariatric surgery
- Chiropractic care
- Hearing aids (age 21 and younger, covered up to $2,000 per ear every 36 months)
- Infertility treatment
- Routine eye exam (adult)
- Routine foot care (covered for diabetes and some circulatory diseases)
- Weight loss program (coverage for six months of membership fees in a Jenny Craig or Weight Watchers program for either a covered Subscriber or one covered Dependent)

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 are: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. 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: Customer Service at **1-866-414-5533 (toll free) or 711 (TTY)**.

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:

Para obtener asistencia en Español, llame al **1-866-414-5533.**

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

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** **$2,000**
- **Specialist copayment** **$60**
- **Hospital (facility)** **$1,000 copayment after IN deductible**

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	$2,000
Copayments	$2,120
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$4,130**

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

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$60**
- **Hospital (facility)** **$1,000 copayment after IN deductible**

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	$2,000
Copayments	$3,560
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$5,560**

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

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$60**
- **Hospital (facility)** **$1,000 copayment after IN deductible**

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	$1,380
Copayments	$420
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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