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 1-888-773-6590. 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 1-888-773-6590 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $6,500 individual / $13,700 family Out-of-network providers: $13,000 individual / $27,400 family Benefit Period: 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 meets the overall family deductible (Embedded).
Are there services covered before you meet your deductible?	Yes. Generic Prescription drugs, Preventive care and primary 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?	Network Providers: $7,350 individual / $14,700 family Out-of-network providers: Unlimited	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 (Embedded).
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain Preauthorization for services, 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?	Yes. This plan uses the Multiplan PHCS Practitioner Only Network (Practitioner refers to Physician only). A list of network providers can be found at www.multiplan.com or call 1-866-930-7427.	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 provider before you get services. For Facility Based Providers (i.e. Hospitals, Free Standing Radiology): This plan covers all providers at the same benefit level regardless of network.
Do you need a referral to see a specialist?	No	You can see a 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	$50 copay/per visit	40% coinsurance after deductible	None
	Specialist visit	$70 copay/per visit	40% coinsurance after deductible	None
	Preventive care/screening/ immunization	No Charge	40% coinsurance after deductible	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 labs and imaging performed in the office setting, independent lab setting, and independent imaging setting are no charge. Diagnostic labs and imaging performed in a facility setting are subject to member cost share
	Diagnostic test (lab, x-ray, radiology)	No Charge	40% coinsurance after deductible	
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	40% coinsurance after deductible Plan Payment based on 150% of Medicare Allowable Payment	Preauthorization is required or benefit will be denied. Diagnostic labs and imaging performed in the office setting, independent lab setting, and independent imaging setting are no charge. Diagnostic labs and imaging performed in a facility setting are subject to member cost share
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.magellanrx.com or call **1-800-424-0472**	Generic drugs	$10 copay retail $20 copay mail order	Not Covered	Retail: Up to a 31-day supply Mail-Order: Up to a 90-day supply Generic Contraceptives covered at No Charge. All other Generic Drugs covered at $10 copay, excluding high cost generics over $250. Deductible applies for Preferred Brand Drugs.
	Preferred brand drugs	No Charge after deductible	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible Plan Payment based on 150% of Medicare Allowable Payment		Preauthorization is required or benefit will be denied. Outpatient Hospital setting Not Covered. Covered only in Office or Urgent Care setting
	Physician/surgeon fees	No Charge after deductible	40% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	No Charge after deductible Plan Payment based on 150% of Medicare Allowable Payment		All facilities are covered as in-network subject to meeting "emergency" criteria.
	Emergency medical transportation	Not Covered		No Coverage for emergency transportation
	Urgent care	$50 copay/per visit	40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible Plan Payment based on 150% of Medicare Allowable Payment		Preauthorization is required or benefit will be denied.
	Physician/surgeon fees	No Charge after deductible	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$70 copay/per visit	40% coinsurance after deductible	Outpatient Hospital setting Not Covered. Covered in Office Setting only.
	Inpatient services	No Charge after deductible Plan Payment based on 150% of Medicare Allowable Payment		Preauthorization is required or benefit will be denied.
If you are pregnant	Office visits	No Charge	40% coinsurance after deductible	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. lab, X-ray, ultrasound). Preauthorization is required for inpatient stay over 48 hours for a vaginal delivery or 96 hours for a cesarean section.
	Childbirth/delivery professional services	No Charge after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	No Charge after deductible Plan Payment based on 150% of Medicare Allowable Payment		
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	No coverage for home health care.
	Rehabilitation services	Not Covered	Not Covered	No coverage for rehabilitation services.
	Habilitation services	Not Covered	Not Covered	No coverage for habilitative services.
	Skilled nursing care	Not Covered	Not Covered	No coverage for skilled nursing care.
	Durable medical equipment	Not Covered	Not Covered	Breast Pumps covered up to $250, one per delivery. Purchase and submit receipt for reimbursement

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)	
	Hospice services	Not Covered	Not Covered	No coverage for hospice service.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for vision
	Children's glasses	Not Covered	Not Covered	No coverage for Glasses
	Children's dental check-up	Not Covered	Not Covered	No coverage for Dental

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	• Hearing Aids
• Ambulance	• Habilitation Services	• Private Duty Nursing
• Bariatric Surgery	• Non-Emergency Care in the ER setting	• Foot Care
• Chiropractic Care	• Non-Emergency Care outside US	• Infertility Services
• Dental Care	• Eye Care and Hardware (adult)	• Hospice Care
• Weight Loss Programs	• Skilled Nursing	• TMJ Treatment
• Durable Medical Equipment, except for breast pumps	• Rehabilitation Services	• Sleep Study
• Long-Term Care	• Surgery in Outpatient Facility	•
• Outpatient Diagnostic Imaging	• Home Health Care	•

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

•	•	•

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-888-773-6590. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, 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: 1-888-773-6590.

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-773-6590.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-773-6590.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-773-6590.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-773-6590.

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	$6500
Specialist copayment	$70
Hospital (facility) coinsurance	$0
Other coinsurance	$0

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,500
Copayments	$140
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,700**

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

The plan's overall deductible	$6500
Specialist copayment	$70
Hospital (facility) coinsurance	$0
Other coinsurance	$0

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$134
Copayments	$840
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,365
The total Joe would pay is	**$6,349**

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

The plan's overall deductible	$6500
Specialist copayment	$70
Hospital (facility) coinsurance	$0
Other coinsurance	$0

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$625
Copayments	$210
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,007
The total Mia would pay is	**$1,842**

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