




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, visit [www.myevhc.com](http://www.myevhc.com) or call 1-800-311-3842. 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.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-877-267-2323 extension 61565 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For preferred <a href="#">providers</a> : \$2,800/Individual; \$5,400/family Non-preferred <a href="#">providers</a> : \$5,000/Individual, \$10,000/Family.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</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> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For preferred <a href="#">providers</a> : \$3,500/Individual \$7,000/Family Non-preferred <a href="#">providers</a> : \$10,000/Individual \$20,000/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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, <a href="#">balance-billed</a> charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myevhc.com">www.myevhc.com</a> for a list of <a href="#">network providers</a> or call 1-800-311-3842.	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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without permission from this <a href="#">plan</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
		Preferred Provider Network (You will pay the least)	Non-Preferred Provider Network (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	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	None.
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">providers</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	In Physician's Office: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> . Outpatient/Independent Facility: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> . Hospital: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	None.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	None.

\* For more information about limitations and exceptions, see the plan or policy document at [www.myevhc.com](http://www.myevhc.com).

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider Network (You will pay the least)	Non-Preferred Provider Network (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.Caremark.com">www.Caremark.com</a>	Generic drugs	Retail: \$10 <a href="#">copay</a> /prescription after <a href="#">deductible</a> . Mail Order: \$25 <a href="#">copay</a> /prescription after <a href="#">deductible</a> .		<a href="#">Copay</a> applies to a 31-day supply Retail, 32-90-day supply Mail Order, and 90-day supply of maintenance medications at any CVS Pharmacy.  <a href="#">Copay</a> and <a href="#">deductible</a> do not apply to preventive drugs required by the Affordable Care Act. Members will be reimbursed up to the Caremark contracted rate minus the <a href="#">deductible</a> and <a href="#">copay</a> for <a href="#">non-participating pharmacy</a> .  <a href="#">Specialty Drugs</a> are limited to a 31-day supply for Retail and Mail Order.
	Preferred brand drugs	Retail: \$35 <a href="#">copay</a> /prescription after <a href="#">deductible</a> . Mail Order: \$87.50 <a href="#">copay</a> /prescription after <a href="#">deductible</a> .		
	Non-preferred brand drugs	Retail: \$60 <a href="#">copay</a> /prescription after <a href="#">deductible</a> . Mail Order: \$150 <a href="#">copay</a> /prescription after <a href="#">deductible</a> .		
	<a href="#">Specialty drugs</a>	\$60 <a href="#">copay</a> /prescription after <a href="#">deductible</a> .		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	None.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	None.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .		None.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .		None.
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	<a href="#">Preauthorization</a> is required. If <a href="#">Preauthorization</a> is not obtained then a \$300 penalty will apply.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	None.

\* For more information about limitations and exceptions, see the plan or policy document at [www.myevhc.com](http://www.myevhc.com).

 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
		Preferred Provider Network (You will pay the least)	Non-Preferred Provider Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	None.
	Inpatient services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	<a href="#">Preauthorization</a> is required. If <a href="#">Preauthorization</a> is not obtained then a \$300 penalty will apply.
If you are pregnant	Office visits	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).  <a href="#">Preauthorization</a> is required. If <a href="#">Preauthorization</a> is not obtained then a \$300 penalty will apply.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	Limited to 60 visits/calendar year. <a href="#">Preauthorization</a> is required. If <a href="#">Preauthorization</a> is not obtained then a \$300 penalty will apply.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	Physical, Occupational and speech Therapy: Limited to 20 visits/calendar year each. Chiropractic Care/Manipulation Therapy: Limited to 24 visits/calendar year.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	None.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	<a href="#">Preauthorization</a> is required. Limited to 120 visits/calendar year. If <a href="#">Preauthorization</a> is not obtained then a \$300 penalty will apply.

\* For more information about limitations and exceptions, see the plan or policy document at [www.myevhc.com](http://www.myevhc.com).

 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
		Preferred Provider Network (You will pay the least)	Non-Preferred Provider Network (You will pay the most)	
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	None.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> .	<a href="#">Preauthorization</a> is required. If <a href="#">Preauthorization</a> is not obtained then a \$300 penalty will apply.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	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](#).)**

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> <li>• Dental Care</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Long Term Care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private Duty Nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul> |
|---|---|---|

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

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Chiropractic Care</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing Aids (limitations apply)</li> </ul> |
|---|--|

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

**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 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](#).

—————*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>	\$2,700
■ <a href="#">Specialist copayment</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### 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>\$12,840</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,500
Copayments	\$40
Coinsurance	\$1,260
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,860</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>	\$2,700
■ <a href="#">Specialist copayment</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### 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>\$7,460</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3,500
Copayments	\$770
Coinsurance	\$470
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$4,800</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>	\$2,700
■ <a href="#">Specialist copayment</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### 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>\$2,010</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,730
Copayments	\$0
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,930</b>