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 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 or call 1-877-267-2323 extension 61565 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For preferred providers: $3,500/Individual; $7,000/family Non-preferred providers: Not Applicable	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. 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?	For preferred providers: $5,000/Individual $10,000/Family Non-preferred providers: Not Applicable	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-billed 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 out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myevhc.com for a list of network providers or call 1-800-311-3842.	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 permission from this plan.

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 provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible.	Not Covered	None.
	Specialist visit	20% coinsurance after deductible.	Not Covered	None.
	Preventive care/screening/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your providers if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	In Physician's Office: 20% coinsurance after deductible. Outpatient/Independent Facility: 20% coinsurance after deductible. Hospital: 20% coinsurance after deductible.	Not Covered	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible.	Not Covered	None.

* For more information about limitations and exceptions, see the plan or policy document at 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: Preferred Provider Network (You will pay the least)	What You Will Pay: Non-Preferred Provider Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Caremark.com	Generic drugs	Retail: $10 copay/prescription after deductible. Mail Order: $25 copay/prescription after deductible.		Copay applies to a 31-day supply Retail, 32-90-day supply Mail Order, and 90-day supply of maintenance medications at any CVS Pharmacy. Copay and deductible do not apply to preventive drugs required by the Affordable Care Act. Members will be reimbursed up to the Caremark contracted rate minus the deductible and copay for non-participating pharmacy. Specialty Drugs are limited to a 31-day supply for Retail and Mail Order.
	Preferred brand drugs	Retail: $35 copay/prescription after deductible. Mail Order: $87.50 copay/prescription after deductible.		
	Non-preferred brand drugs	Retail: $60 copay/prescription after deductible. Mail Order: $150 copay/prescription after deductible.		
	Specialty drugs	$60 copay/prescription after deductible.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible.	Not Covered	None.
	Physician/surgeon fees	20% coinsurance after deductible.	Not Covered	None.
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible.		None.
	Emergency medical transportation	20% coinsurance after deductible.		None.
	Urgent care	20% coinsurance after deductible.	Not Covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible.	Not Covered	Preauthorization is required. If Preauthorization is not obtained then a $300 penalty will apply.
	Physician/surgeon fees	20% coinsurance after deductible.	Not Covered	None.

* For more information about limitations and exceptions, see the plan or policy document at 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	20% coinsurance after deductible.	Not Covered	None.
	Inpatient services	20% coinsurance after deductible.	Not Covered	Preauthorization is required. If Preauthorization is not obtained then a $300 penalty will apply.
If you are pregnant	Office visits	20% coinsurance after deductible.	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required. If Preauthorization is not obtained then a $300 penalty will apply.
	Childbirth/delivery professional services	20% coinsurance after deductible.	Not Covered	
	Childbirth/delivery facility services	20% coinsurance after deductible.	Not Covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible.	Not Covered	Limited to 60 visits/calendar year. Preauthorization is required. If Preauthorization is not obtained then a $300 penalty will apply.
	Rehabilitation services	20% coinsurance after deductible.	Not Covered	Physical, Occupational and speech Therapy: Limited to 20 visits/calendar year each. Chiropractic Care/Manipulation Therapy: Limited to 24 visits/calendar year.
	Habilitation services	20% coinsurance after deductible.	Not Covered	None.
	Skilled nursing care	20% coinsurance after deductible.	Not Covered	Preauthorization is required. Limited to 120 visits/calendar year. If Preauthorization 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.

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)	
	Durable medical equipment	20% coinsurance after deductible.	Not Covered	None.
	Hospice services	20% coinsurance after deductible.	Not Covered	Preauthorization is required. If Preauthorization 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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- 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.)

- Chiropractic Care
- Hearing Aids (limitations apply)

* For more information about limitations and exceptions, see the plan or policy document at www.myevhc.com.

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. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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.*———————————

* For more information about limitations and exceptions, see the plan or policy document at www.myevhc.com.

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	$3,500
Specialist copayment	20%
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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,750
Copayments	$0
Coinsurance	$2,250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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

The plan's overall deductible	$3,500
Specialist copayment	20%
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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$770
Coinsurance	$590
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,920**

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

The plan's overall deductible	$3,500
Specialist copayment	20%
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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,540
Copayments	$0
Coinsurance	$390
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,930**

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