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.claimchoice.com.
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 1-800-221-4254 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$4,000/individual or $8,000/family for services rendered by eligible providers. The overall deductible will be reduced to $4,000/individual or family for services coordinated by Sympl Care and subsequently billed by Sympl Benefits, LLC.	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, routine immunizations administered in a pharmacy or at the Department of Community Health, and certain preventive prescription drugcoverage 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?	$7,000/individual and $14,000/family for services rendered by eligible providers.	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?	Penalties; charges that exceed the plan's usual, customary, and reasonable fee allowance or are in excess of stated maximums; premiums; balance-billing charges; and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	This plan uses PNOA network for facility procedures and HealthSmart for physician and ancillary procedures. If your provider is not part of the PPO network, you will pay the same as if they were. If you get a Balance Bill please contact ClaimChoice for directions on handling that.	You can receive covered services from any provider.
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
		In-Network Provider	Out-of-Network Provider Not Applicable	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	No charge after deductible will apply to eligible services coordinated by Sympl Care and subsequently billed by Sympl Benefits, LLC.
	Specialist visit	20% coinsurance	20% coinsurance	No charge after deductible will apply to eligible services coordinated by Sympl Care and subsequently billed by Sympl Benefits, LLC. Certification (sometimes called preauthorization) is required for infusion or injection of select products. No coverage for the infusion or injection of select products if provider/site of service is not approved.
	Preventive care/screening/ immunization	No charge	N/A	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider Not Applicable	
If you have a test	Diagnostic test (X-ray, blood work)	20% coinsurance	N/A	No charge after deductible will apply to eligible services coordinated by Sympl Care and subsequently billed by Sympl Benefits, LLC.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	N/A	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.southernscripts.net	Rx formulary tier 1 (most generic drugs and some low-cost brand drugs)	$15 copay/prescription (retail) or $30 copay/prescription (mail order); deductible does not apply to certain preventive drugs		Covers up to a 30-day supply (retail)or up to a 90-day supply (mail order). A greater day supply of a medication may be purchased at a retail pharmacy for an increased copay. Specific criteria must be met in order for some high-cost medications to be covered. Specialty drugs are limited to a 30- day dispensing supply and must generally be purchased through thedesignated specialty pharmacy. If you are eligible to receive a subsidy through a manufacturers copay program, your copayment under the Variable Copay Program will be equal to the maximum subsidy available through that manufacturer copay program. Any manufacturer copay subsidy obtained under the Variable Copay Program will not accumulate toward your deductible or out of pocket cost. If you are receiving a prescription drug through a manufacturer free drug program and you enroll int eh Manufacturer Free Drug Initiative, that drug will not be covered under the plan.
	Rx formulary tier 2 (preferred brand drugs and may include some high-cost generic drugs)	$50 copay/prescription (retail) or $100 copay/prescription (mail order); deductible does not apply to certain preventive drugs		
	Rx formulary tier 3 (generally all non-preferred drugs [brand and generic])	Copays vary depending on manufacture. Deductible does not apply to certain preventive drugs		
	Specialty drugs	Copays vary depending on manufacturer.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	N/A	No charge after deductible will apply to eligible services coordinated by Sympl Care and subsequently billed by Sympl Benefits, LLC.
	Physician/surgeon fees	20% coinsurance	N/A	
	Emergency room care	20% coinsurance	N/A	None

If you need immediate medical attention	Emergency medical transportation	20% coinsurance	N/A	Air ambulance transport is covered only when the patient is taken to the nearest facility that can treat him or her and no other method of emergency medical transportation is appropriate.
	Urgent care	20% coinsurance	N/A	No charge after deductible will apply to eligible services coordinated by Sympl Care and subsequently billed by Sympl Benefits, LLC.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	N/A	Certification (sometimes called preauthorization) is required. No charge after deductible will apply to eligible services coordinated by Sympl Care and subsequently billed by Sympl Benefits, LLC.
	Physician/surgeon fees	20% coinsurance	N/A	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	N/A	None
	Inpatient services	20% coinsurance	N/A	Certification (sometimes called preauthorization) is required.
If you are pregnant	Office visits	20% coinsurance	N/A	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or a deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	N/A	
	Childbirth/delivery facility services	20% coinsurance	N/A	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	N/A	Certification (sometimes called preauthorization) is required.
	Rehabilitation services	20% coinsurance	N/A	
	Habilitation services	20% coinsurance with an eligible diagnosis (e.g., autism spectrum disorder); otherwise not covered	N/A	
	Skilled nursing care	20% coinsurance	N/A	Certification (sometimes called preauthorization) is required for infusion or injection of select products. No coverage for the infusion or injection of select products if provider/site of service is not approved.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs, cont.	Durable medical equipment	20% coinsurance	N/A	Certification (sometimes called preauthorization) is required if the item costs $2,500 or more. Vehicle and home modifications are excluded.
	Hospice services	20% coinsurance	N/A	None
If your child needs dental or eye care	Children's eye exam	Not covered (except to the extent required by law)	N/A	No coverage for routine eye care under the medical plan, except as required by Health Care Reform.
	Children's glasses	Not covered	N/A	No coverage for glasses under the medical plan.
	Children's dental check-up	Not covered (except to the extent required by law)	N/A	No coverage for routine dental care under the medical plan, except as required by Health Care Reform.

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 (except to the extent required to be covered by Health Care Reform)
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (except to the extent required to be covered by Health Care Reform)
- 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 up to 30 chiropractic visits allowed annually
- 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: 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 1-800-221-4254.

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: ClaimChoice Administrators at 1-800-221-4254 You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit their website at www.dol.gov/ebsa/healthreform. Additionally, a Consumer Assistance Program may be able to help you file your appeal. Visit http://www.healthcare.gov/law/features/rights/consumer-assistance-program/index.html to see if your state has a Consumer Assistance Program that may be able to help you file your appeal.

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.

Language Access Services:
Para obtener asistencia en Español, llame al 1-800-221-4254.

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.

Sue is Having a Baby
(9 months of pree-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,800**
- **Specialist coinsurance** **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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$4,000
Copayments	$40
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,100**

Managing Jack's Type 2 Diabetes
(a year of routine care of a well-controlled condition)

- **The plan's overall deductible** **$2,800**
- **Specialist coinsurance** **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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$4,000
Copayments	$1,000
Coinsurance	$90
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$5,150**

Mike's Simple Fracture
(emergency room visit and followup care)

- **The plan's overall deductible** **$2,800**
- **Specialist coinsurance** **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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

Note: These numbers assume the patient has not been reimbursed by the Health Savings Account. If you are eligible for reimbursement under the Health Savings Account, your costs may be lower.

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