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.dol.gov/ebsa/healthreform or call 1-888-773-6590 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $0 Out-of-network providers: Not Covered	N/A
Are there services covered before you meet your deductible?	N/A	Not applicable as this plan has no deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	Network providers: $5,000 individual / $10,000 family Out-of-network providers: Not Covered	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-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 Prime Health Services Preventive Services Only Network. A list of network providers can be found at www.primehealthservices.com or call 1-888-773-6590.	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 Non-Facility Based Providers: This plan with exception of emergency care will only pay for services performed by an in-network provider. 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	$15 copay	Not Covered	Limited to 12 visits per calendar year. Telemedicine covered at no charge with no limitations.
	Specialist visit	$25 copay	Not Covered	Limited to 12 visits per calendar year. Telemedicine covered at no charge with no limitations.
	Preventive care/screening/ immunization	No Charge	Not Covered	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 test (x-ray, blood work)	$50 copay	Not Covered	Limited to 4 visits per calendar year.
	Imaging (CT/PET scans, MRIs)	$350 copay	Not Covered	Benefits administered through One Call Outpatient Diagnostic only. Limited to 3 visits per calendar year.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.magellanrx.com or call **1-800-443-5715**	Generic drugs	20% copay	Not Covered	Generic and Limited Brand drug plan. Limited to $150 per prescription, retail only.
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copay	Not Covered	Limited to 2 visits per calendar year.
	Physician/surgeon fees	No Charge	Not Covered	Limited to 4 days per calendar year.
If you need immediate medical attention	Emergency room care	$350 copay		Limited to 2 visits per calendar year.
	Emergency medical transportation	$250 copay		Limited to 2 visits per calendar year ground only.
	Urgent care	$35 copay	Not Covered	Limited to 3 visits per calendar year.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay per admission	Not Covered	Limited to 10 days per calendar year.

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)	
	Physician/surgeon fees	No Charge	Not Covered	Limited to 10 days per calendar year.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay	Not Covered	Limited to 10 days per calendar year.
	Inpatient services	$250 copay	Not Covered	Limited to 10 days per calendar year.
If you are pregnant	Office visits	$15 copay	Not Covered	Combined with PCP 12 visit max per Calendar year.
	Childbirth/delivery professional services	No Charge	Not Covered	Preauthorization is required for inpatient stay over 48 hours for a vaginal delivery or 96 hours for a cesarean section. Inpatient limited to 10 days per calendar year. Outpatient limited to 2 visits per calendar year.
	Childbirth/delivery facility services	No Charge	Not Covered	Preauthorization is required for inpatient stay over 48 hours for a vaginal delivery or 96 hours for a cesarean section. Inpatient limited to 10 days per calendar year. Outpatient limited to 2 visits per calendar year.
If you need help recovering or have other special health needs	Home health care	$25 copay	Not Covered	Limited to 20 days per calendar year.
	Rehabilitation services	Not Covered	Not Covered	None
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Not Covered	Not Covered	None
	Durable medical equipment	Not Covered	Not Covered	None
	Hospice services	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)		
• Bariatric Surgery	• Cosmetic Surgery	• Hearing Aids
• Long-Term Care	• Non-Emergency Care outside US	• Private Duty Nursing
• Routine Dental Care	• Routine Eye Care	• Routine Foot Care
• Weight Loss Programs	• Skilled Nursing	• Infertility Services
• Durable Medical Equipment	• Acupuncture	• Hospice Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Inpatient Admission	• Outpatient Services	• Office Visits
• Emergency Room	• Emergency Transport	• Home Health

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	$0
Specialist copayment	$25
Hospital (facility) coinsurance	100%
Other coinsurance	100%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,731
The total Peg would pay is	**$12,731**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	100%
Other coinsurance	100%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,389
The total Joe would pay is	**$7,389**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	100%
Other coinsurance	100%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,925
The total Mia would pay is	**$1,925**

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