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: None Out-of-network providers: Not Covered Benefit Period: Calendar 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 meet the overall family deductible.
Are there services covered before you meet your deductible?	Not applicable.	Not applicable as this Plan has no deductible.
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: $1,850 Individual / $12,700 Family Out-of-network providers: No Maximum	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 Only Network (Practitioner refers to Physician only). 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.
Do you need a referral to see a specialist?	No	You can see a specialist you choose without a referral

- Copayment are fixed dollar amounts (for example; $15) you pay for covered health care, usually when you receive this service.
- Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount you may have to pay the difference. For example, if an out-of-network provider charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference (this is called balance billing).
- This plan encourages you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

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	$10 copay/per visit	Not Covered	None
	CVS Minute Clinic	$10 copay/per visit	Not Covered	For all services.
	Teledoc/Telemed	No Charge	Not Covered	Telephonic Primary Care Services Only
	Specialist visit	$30 copay/per visit	Not Covered	Office surgical procedures require Preauthorization
	Chiropractic Therapy	$40 copay/per visit	Not Covered	Limit 30 visits per year
	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) in the office	$60 copay/per visit	Not Covered	None
	Diagnostic test (x-ray, blood work) Outpatient	$200 copay/per visit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$200 copay/per visit	Not Covered	Preauthorization is required or benefit will be denied. Sleep Studies are not covered.
If you need drugs to treat your illness or condition More information about prescription drug	Generic drugs	$ 10 copay Retail (30 day supply)	Not Covered	$1,500 without prior authorization per prescription maximum for pharmacy benefit. $3,000 without prior authorization per prescription maximum for mail order benefits. ACA Preventive Care Drugs covered at 100%.
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand 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)	
coverage is available at www.magellanrx.com or call 1-800-443-5715	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	None
	Physician/surgeon fees	Not Covered	Not Covered	None
If you need immediate medical attention	Emergency room care	Not Covered		None
	Emergency medical transportation	Not Covered		None
	Urgent care	$50 copay/per visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	None
	Physician/surgeon fees	Not Covered	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	None
	Office visit services	$30 copay/per visit	Not Covered	None
	Inpatient services	Not Covered	Not Covered	None
If you are pregnant	Office visits	$10 copay at 1st visit then covered at 100%	Not Covered	None
	Childbirth/delivery professional services	Not Covered	Not Covered	
	Childbirth/delivery facility services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	None
	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	$50 copay/per visit	Not Covered	$50 co-pay per month up to the purchase price.
	Hospice services	Not Covered	Not Covered	None
If your child needs	Children's eye exam	No Charge	Not Covered	Covered Per ACA Guidelines

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)	
dental or eye care	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	No Charge	Not Covered	Covered Per ACA Guidelines

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 In and 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

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	$0.00
Specialist copayment	$10.00
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	**$12,800**

In this example, Peg would pay: This condition is not covered, so patient pays 100 percent.

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,800
The total Peg would pay is	**$12,800**

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

The plan's overall deductible	$0.00
Specialist copayment	$30.00
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: This condition is not covered, so patient pays 100 percent.

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,460
The total Joe would pay is	**$7,460**

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

The plan's overall deductible	$0.00
Specialist copayment	$30.00
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	**$1,925**

In this example, Mia would pay: This condition is not covered, so patient pays 100 percent.

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**