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, www.ebsobenefits.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.dol.gov/ebsa/healthreform or call 1-800-558-7798 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250/Individual or $750/family For Non-network physician: $500/Individual or $1,500/family	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 and primary care services 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?	$1,250/Individual or $3,750/family For Non-network physician: $2,500/Individual or $7,500/family	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 for non-compliance with plan provisions; 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.
Will you pay less if you use a network provider?	Yes. See www.multiplan.com for a list of network providers. Network applies to Physician only. It does not apply to facility and ancillary providers. (Ancillary providers may include: Independent lab, urgent care, home health, durable medical equipment, skilled nursing, and ambulance/air ambulance)	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 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
		Hospital/Facility Services	Ancillary Provider and Network Physician (You will pay the least)	Out-of-Network Physician (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	$25 copay/office visit; deductible does not apply	$25 copay/office visit; deductible does not apply	40% coinsurance	Chiropractic care: 18 visits/year
	Specialist visit	$45 copay/office visit; deductible does not apply	$45 copay/office visit; deductible does not apply	40% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	Breast pumps: No charge All other: not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	40% coinsurance	Labs performed during network office visit are included in office visit copay.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pti-nps.com	Generic drugs (Tier 1)	No charge (retail/mail order)			Must use participating pharmacy. Non-participating pharmacies are NOT covered. Certain contraceptives and smoking deterrents are covered at no charge. Covers up to a 30-day supply (retail); 3 month supply (mail order). Specialty drugs are limited to a 30 day supply.
	Preferred brand drugs (Tier 2)	$35 copay/ prescription (retail) $70 copay/ prescription (mail order); deductible does not apply			
	Non-preferred brand drugs (Tier 3)	$75 copay/ prescription (retail) $150 copay/ prescription (mail order); deductible does not apply			
	Specialty drugs (Tier 4)	$150 copay/ prescription (retail/mail order). Specialty drugs are limited to a 30 day supply. Deductible does not apply.			

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not applicable	Not applicable	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Paid as PPO	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Paid as PPO	
	Urgent care	$45 copay/office visit; deductible does not apply	$45 copay/office visit; deductible does not apply	$45 copay/office visit; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not applicable	Not applicable	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	$25 copay/office visit; deductible does not apply All other: 20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
	Inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	Not applicable	$25 copay/office visit; deductible does not apply	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	20% coinsurance	60 days/year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
	Rehabilitation services	20% coinsurance	20% coinsurance	40% coinsurance	Physical, speech, occupational,

	Habilitation services	20% coinsurance	20% coinsurance	40% coinsurance	cardiac rehabilitation: 35 visits/ year, combined. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
	Skilled nursing care	20% coinsurance	20% coinsurance	20% coinsurance	25 days/year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
	Durable medical equipment	20% coinsurance	20% coinsurance	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500.
	Hospice services	20% coinsurance	20% coinsurance	20% coinsurance	15 visit/days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	none
	Children's glasses	Not covered	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	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 except for certain oral surgeries or treatment to sound natural teeth required when due to injury.
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Private Duty Nursing, except as covered under home health
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- 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
- Non-emergency care when traveling outside the U.S. unless the Plan Member traveled outside of the U.S. for purpose of obtaining medical services, supplies, or drugs.

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 1-866-444-3272 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 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-558-7798.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

ust 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.

The total Peg would pay is	**$3,260**

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ **The plan's overall deductible**	**$250**
■ **Specialist copay**	**$45**
■ **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	$250
Copayments	$70
Coinsurance	$930
What isn't covered	
Limits or exclusions	$2,010

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

■ **The plan's overall deductible**	**$250**
■ **Specialist copay**	**$45**
■ **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*	$0
Copayments	$1,250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,310**

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

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

The plan's overall deductible	**$250**
Specialist copay	**$45**
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*	$250
Copayments	$90
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$640**

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