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 Benefit Risk & Management Services (BRMS) at 1-888-245-5067 or visit www.MyHealthBenefits.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 BRMS at 1-888-245-5067 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: $3,000 / Family: $6,000	Generally, you must pay all 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, provider office visits, urgent care, lab services and imaging when ordered by your DPC, lab services directly contracted laboratory, certain habilitation and rehabilitation therapy, and prescription drugs.	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 www.healthcare.gov/coverage/preventative-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?	Individual: $9,000 / Family: $18,000	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, copayments on certain services; and penalties for failing to obtain pre-certification for certain services.	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?	There is no network, please contact ClaimDOC at 1-888-330-7295 or visit portal.claim-doc.com for assistance.	This plan does not use a provider network. 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 Network Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copay/visit, deductible does not apply	Office visit copay includes office visits, lab tests, x-rays, and allergy testing. All other services are deductible then 20% coinsurance.
	Specialist visit	$75 copay/visit, deductible does not apply	Office visit copay includes office visits, lab tests, x-rays, and allergy testing. All other services are deductible then 20% coinsurance.
	Preventive care/screening/ immunization	No charge	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Preauthorization is recommended.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.truescripts.com or call **844-257-1955**	1-30 day supply (Generic & brand) $0.00 - $15.00 $15.01 - $50.00 $50.01 - $100.00 $100.01 - $200.00 $200.01 - $500.00 $500.01 - $1,000.00 $1,000.01 - $1,500.00 $1,500.01 - $5,000.00	Paid at 100% $15 copay per prescription $20 copay per prescription $40 copay per prescription $50 copay per prescription $100 copay per prescription 20% coinsurance up to $300 maximum $300 copay per prescription	Not covered	The deductible does not apply. If you choose a brand drug when a generic drug is available, and the prescriber does not indicate Dispense as Written, you pay the generic copay Plus the difference in cost between the generic and the brand name drug.
	31-90 day supply (Generic & brand) $0.00 - $30.00 $30.01 - $100.00 $100.01 - $200.00 $200.01 - $400.00 $400.01 - $1,000.00 $1,000.01 - $2,000.00 $2,000.01 - $3,000.00 $3,000.01 - $5,000.00	Paid at 100% $30 copay per prescription $40 copay per prescription $80 copay per prescription $100 copay per prescription $200 copay per prescription 20% coinsurance up to $600 maximum $600 copay per prescription	Not covered	The deductible does not apply If you choose a brand drug when a generic drug is available, and the prescriber does not indicate Dispense as Written, you pay the generic copay PLUS the difference in cost between the generic and the brand name drug.
	Specialty drugs	$300 copay/prescription	Not covered	The deductible does not apply. Limited to a 30 day supply. Specialty drugs must be preauthorized.

Common Medical Event	Services You May Need	What You Will Pay Network Provider	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Preauthorization is recommended.
	Physician/surgeon fees	Deductible then 20% coinsurance	None
If you need immediate medical attention	Emergency room care	$400 copay, deductible then 20% coinsurance	Copay is waved if admitted as inpatient
	Emergency medical transportation	Deductible then 20% coinsurance	Air ambulances are limited to 140% of the Medicare rate.
	Urgent care	$200 copay per visit, (deductible does not apply)	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Preauthorization is recommended.
	Physician/surgeon fees	Deductible then 20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $50 copay, (deductible does not apply) Other services: Deductible then 20% coinsurance	None
	Inpatient services	Deductible then 20% coinsurance	Preauthorization is recommended.
If you are pregnant	Office visits	Deductible then 20% coinsurance	An office visit copay may apply for initial visit only. Preauthorization is recommended if the stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean delivery. Benefits are limited to employee or spouse only, except for routine services required under the USPSTF.
	Childbirth/delivery professional services	Deductible then 20% coinsurance	
	Childbirth/delivery facility services	Deductible then 20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay Network Provider	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Limited to 60 visits per calendar year.
	Rehabilitation services	Spooner PT: No charge Occupational, physical, and speech therapy: $50 copay per visit, (deductible does not apply) Pulmonary and cardiac rehabilitation: $75 copay per visit, (deductible does not apply) All other services: deductible then 20% coinsurance	Use of Spooner PT is mandatory within coverage area (within 75 miles). Services available at Spooner have no limits on the number of visits per calendar year. Occupational, physical, and speech therapy are each limited to 26 visits per calendar year. Cardiac and pulmonary rehabilitation are each limited to 36 visits per calendar year. Chiropractic and massage are excluded. Preauthorization is recommended for inpatient.
	Habilitation services	Spooner PT: No charge Occupational, physical, and speech therapy $50 copay per visit, (deductible does not apply) All other services: deductible then 20% coinsurance	
	Skilled nursing care	Deductible then 20% coinsurance	Limited to 60 visits per calendar year. Preauthorization is recommended for inpatient.
	Durable medical equipment	Deductible then 20% coinsurance	Preauthorization is recommended if DME cost is over $500.
	Hospice services	Deductible then 20% coinsurance	Preauthorization is recommended for inpatient.
If your child needs dental or eye care	Children's eye exam	Not covered	Certain ACA required services are covered under preventive care.
	Children's glasses	Not covered	Certain ACA required services are covered under preventive care.
	Children's dental check-up	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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- 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.)

- Hearing aids (for children 18 and under)
- Temporomandibular Joint Disorder (TMJ)

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform and BRMS at 1-888-245-5067. 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 BRMS at 1-888-245-5067.

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 on how 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 BRMS at 1-888-245-5067.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 1-888-245-5067

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	**$3,000**
Specialist copayment	**$75**
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$86
Coinsurance	$1,913
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$5,050**

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

The plan's overall deductible	**$3,000**
Physician copayment	**$50**
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$913
Copayments	$239
Coinsurance	$0
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$1,120**

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

The plan's overall deductible	**$3,000**
Specialist copayment	**$75**
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,090
Copayments	$570
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,660**

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