




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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-888-245-5067 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	Individual: \$500 / Family: \$1,000	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventative care</a> , <a href="#">provider</a> office visits, <a href="#">urgent care</a> , lab services and imaging when ordered by your DPC, lab services directly contracted laboratory, certain <a href="#">habilitation</a> and <a href="#">rehabilitation</a> therapy, and <a href="#">prescription drugs</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive care</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive care</a> at <a href="http://www.healthcare.gov/coverage/preventive-carebenefits/">www.healthcare.gov/coverage/preventive-carebenefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Individual: \$6,000 / Family: \$12,000	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> on certain services, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	
Will you pay less if you use a <a href="#">network provider</a> ?	There is no network, please contact ClaimDOC at 1-888-330-7295 or visit <a href="http://portal.claim-doc.com">portal.claim-doc.com</a> for assistance.	This <a href="#">plan</a> does not use a <a href="#">provider network</a> . You can receive covered services from any <a href="#">provider</a> .
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	<p>Direct Primary Care (DPC): No Charge</p> <p>Pediatric &amp; OBGYN: \$50 <a href="#">copay</a>/visit, <a href="#">deductible</a> does not apply</p> <p>All Other Primary Care: \$75 <a href="#">copay</a>/visit, <a href="#">deductible</a> does not apply</p>	Office visit <a href="#">copay</a> includes office visits, lab tests, x-rays, and allergy testing. All other services are <a href="#">deductible</a> then 20% <a href="#">coinsurance</a> .
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	Office visit <a href="#">copay</a> includes office visits, lab tests, x-rays, and allergy testing. All other services are <a href="#">deductible</a> then 20% <a href="#">coinsurance</a> .
	<a href="#">Preventive care/screening</a> immunization	No Charge	You may have to pay for services that are not <a href="#">preventive</a> . Ask your provider if the services needed are <a href="#">preventive</a> . Then check what your plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	No charge when ordered by your DPC, or a directly contracted laboratory is used.
	Imaging (CT/PET scans, MRIs)	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	<p><a href="#">Preauthorization</a> is recommended.</p> <p>No charge when ordered by your DPC.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.TrueScripts.com">prescription drug coverage</a> is available at <a href="http://www.TrueScripts.com">www.TrueScripts.com</a>	<b>1-30 day supply</b> (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 <a href="#">copay</a> /prescription \$20 <a href="#">copay</a> /prescription \$40 <a href="#">copay</a> /prescription \$50 <a href="#">copay</a> /prescription \$100 <a href="#">copay</a> /prescription 20% <a href="#">coinsurance</a> up to \$300 maximum \$300 <a href="#">copay</a> per prescription	Not covered at other pharmacies	The <a href="#">deductible</a> 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 <a href="#">copay</a> PLUS the difference in cost between the generic and the brand name drug.
	<b>31-90 day supply</b> (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 <a href="#">copay</a> /prescription \$40 <a href="#">copay</a> /prescription \$80 <a href="#">copay</a> /prescription \$100 <a href="#">copay</a> /prescription \$200 <a href="#">copay</a> /prescription 20% <a href="#">coinsurance</a> up to \$600 maximum \$600 <a href="#">copay</a> per prescription	Not covered at other pharmacies	The <a href="#">deductible</a> 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 <a href="#">copay</a> plus the difference in cost between the generic and the brand name drug.
	<a href="#">Specialty drugs</a>	\$300 <a href="#">copay</a> /prescription	Not covered at other pharmacies	The <a href="#">deductible</a> does not apply.  Limited to a 30-day supply.  Specialty drugs must be <a href="#">preauthorized</a> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>		<a href="#">Preauthorization</a> is recommended. No charge when ordered by your DPC.
	Physician/surgeon fees	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>		None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$400 copay/visit, <a href="#">deductible</a> then 20% <a href="#">coinsurance</a>	<a href="#">Copay</a> is waived if referred by your DPC or admitted as inpatient.
	<a href="#">Emergency medical transportation</a>	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	Air ambulance is limited to 140% of the Medicare rate.
	<a href="#">Urgent care</a>	Direct Primary Care (DPC): No Charge  All Other Urgent Care: \$200 <a href="#">copay</a> per visit, ( <a href="#">deductible</a> does not apply)	None
If you have a hospital stay	Facility fee (e.g., hospital room)	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended.
	Physician/surgeon fees	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$50 <a href="#">copay</a> , ( <a href="#">deductible</a> does not apply)  Other services: <a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	None
	Inpatient services	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended.
If you are pregnant	Office visits	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	An office visit <a href="#">copay</a> may apply for initial visit only.
	Childbirth/delivery professional services	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended if the stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean delivery.
	Childbirth/delivery facility services	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	Benefits are limited to employee or spouse only, except for routine services required under the USPSTF.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	Limited to 60 visits per calendar year.
	<a href="#">Rehabilitation services</a>	Spooner PT: No charge  Occupational, physical, and speech therapy: \$50 <a href="#">copay</a> per visit, ( <a href="#">deductible</a> does not apply)  Pulmonary and cardiac rehabilitation: \$50 <a href="#">copay</a> per visit, ( <a href="#">deductible</a> does not apply)  All other services: <a href="#">deductible</a> then 20% <a href="#">coinsurance</a>	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 226 visits per calendar year.  Cardiac and pulmonary rehabilitation are each limited to 36 visits per calendar year.
	<a href="#">Habilitation services</a>	Spooner PT: No charge  Occupational, physical, and speech therapy: \$50 <a href="#">copay</a> per visit, ( <a href="#">deductible</a> does not apply)  All other services: <a href="#">deductible</a> then 20% <a href="#">coinsurance</a>	Chiropractic and massage are excluded.  <a href="#">Preauthorization</a> is recommended for inpatient.
	<a href="#">Skilled nursing care.</a>	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	Limited to 60 visits per calendar year.  <a href="#">Preauthorization</a> is recommended for inpatient.
	<a href="#">Durable medical equipment</a>	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is recommended for inpatient.
	<a href="#">Hospice services</a>	<a href="#">Deductible</a> then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> 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 <a href="#">preventive care</a> .
	Children's glasses	Not covered	Certain ACA required services are covered under <a href="#">preventive care</a> .
	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       | • Dental care   | • Private-duty nursing     |
| • Bariatric surgery | • Infertility treatment                               | • Routine eye care (Adult) |
| • Chiropractic care | • Long-term care                                      | • Routine foot care        |
| • Cosmetic surgery  | • Non-emergency care when traveling outside then U.S. | • 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](http://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](http://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 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

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$11
<a href="#">Coinsurance</a>	\$2,413
<i>What isn't covered</i>	
Limits or exclusions	\$61
<b>The total Peg would pay is</b>	<b>\$2,985</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ Physician <a href="#">copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$239
<a href="#">Coinsurance</a>	\$83
<i>What isn't covered</i>	
Limits or exclusions	\$22
<b>The total Joe would pay is</b>	<b>\$844</b>

### Mia's Simple Fracture

(emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$570
<a href="#">Coinsurance</a>	\$318
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,388</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.