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 (844) 995-5836. 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 (844) 995-5836 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,500 individual / $5,000 family	See the Common Medical Event Chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes, preventive care, prescription drugs and some additional services.	This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply.
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?	$9,100 individual / $18,200 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?	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. Certain services are subject to Reference-Based Pricing (RBP) paying a percentage of the Medicare allowable amount for covered services. This plan pays up to 125% of the Medicare allowable amount for covered services. There may be balance-billing charges if a provider charges beyond 125% of the Medicare allowable amount.
Will you pay less if you use a network provider?	Yes. Visit www.multiplan.com/sbmapa or call 1-800-454-5231 for a list of network providers.	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 don't need a referral to see a specialist for covered services.

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 **copayment**	40% **coinsurance** after **deductible**	None
	Specialist visit	$15 **copayment**	40% **coinsurance** after **deductible**	None
	Preventive care/screening/ immunization	No charge	40% **coinsurance** after **deductible**	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Preventive care benefits may be subject to limitations.
If you have a test	Diagnostic test (x-ray, blood work)	$50 **copayment**	40% **coinsurance** after **deductible**	Excludes outpatient services provided at a hospital and genetic testing.
	Imaging (CT/PET scans, MRIs)	30% **coinsurance**	30% **coinsurance**	Limited to 1 per year and requires precertification. Subject to RBP.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://member.procarerx.com/account/register	Generic drugs (tier 1)	$10 **copayment**	Not covered	Preferred brand, non-preferred brand and Specialty drugs are not covered but are available at a discounted rate. Preventive drugs are provided at no cost but may be subject to coverage limitations. Certain drugs may be subject to step therapy and/or precertification. Coverage is limited to the formulary drug list.
	Preferred brand drugs	Discount only	Not covered	
	Non-preferred brand drugs	Discount only	Not covered	
	Specialty drugs	Discount only	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	Limited to 1 per year and requires precertification. Subject to RBP.
	Physician/surgeon fees	30% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	
If you need immediate medical attention	Emergency room care	30% **coinsurance**	30% **coinsurance**	Limited to 1 per year. Subject to RBP.
	Emergency medical transportation	30% **coinsurance**	30% **coinsurance**	Limited to 1 per year. Ground transportation only. Subject to RBP.
	Urgent care	$50 **copayment**	40% **coinsurance** after **deductible**	None

*For more information about limitations and exceptions, call 1-844 995-5836.

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 have a hospital stay	Facility fee (e.g., hospital room)	30% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	Limited to 5 days and 2 surgeries per year. Requires precertification and subject to RBP.
	Physician/surgeon fees	30% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	
If you need mental health, behavioral health, or substance abuse services	Outpatient mental / behavioral health services	$15 **copayment**	40% **coinsurance** after **deductible**	None
	Inpatient mental / behavioral health services	30% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	Limited to 5 days per year. Requires precertification and subject to RBP.
	Outpatient substance abuse services	30% **coinsurance**	40% **coinsurance** after **deductible**	Limited to 8 days per year and requires precertification.
	Inpatient substance abuse services	30% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	Limited to 5 days per year. Requires precertification and subject to RBP.
If you are pregnant	Office visits	$15 **copayment**	40% **coinsurance** after **deductible**	None
	Childbirth/delivery professional services	$350 **copayment**	40% **coinsurance** after **deductible**	Requires precertification.
	Childbirth/delivery facility services	30% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	Requires precertification. Subject to RBP.
If you need help recovering or have other special health needs	Home health care	$50 **copayment**	40% **coinsurance** after **deductible**	Limited to 10 days per year.
	Rehabilitation services	$50 **copayment**	40% **coinsurance** after **deductible**	Limited to 8 days per year combined with habilitation services.
	Habilitation services	$50 **copayment**	40% **coinsurance** after **deductible**	Limited to 8 days per year combined with rehabilitation services.
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered	Not covered
	Hospice services	Not covered	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

*For more information about limitations and exceptions, call 1-844 995-5836.

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.)

- Abortion
- Acupuncture
- Bariatric Surgery
- Care when traveling outside the United States
- Chemotherapy / Radiation Therapy
- Cosmetic Surgery
- Dental Care
- Dialysis
- Experimental / Investigational Treatments
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing
- Routine Eye Care
- Transplant Services
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Services

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 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: 1-888-505-7724.

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 1-844-995-5836.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-995-5836.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-995-5836.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-995-5836.

Additional language services are available upon request. For more information, please contact the plan administrator at 1-844-995-5836.

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

*For more information about limitations and exceptions, call 1-844 995-5836.

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	$2,500
Specialist copayment	$15
Hospital (facility) coinsurance	30%
Other copayment	$350

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	$2,500
Copayments	$560
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$6,060**

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

The plan's overall deductible	$2,500
Primary care copayment	$15
Specialty drugs	N/A
Durable medical equipment	N/A

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	$0
Copayments	$290
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,200
The total Joe would pay is	**$4,490**

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

The plan's overall deductible	$2,500
Emergency room care	30%
Durable medical equipment	N/A
Rehabilitation services	$50

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	$0
Copayments	$200
Coinsurance	$750
What isn't covered	
Limits or exclusions	$50
The total Mia would pay is	**$1,000**

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