



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 (888) 505-7724. 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](http://www.dol.gov/ebsa/healthreform) or call (888) 505-7724 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0                                                                                                                                                                                    | See the Common Medical Event Chart below for your costs for services this plan covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Not Applicable                                                                                                                                                                         | There are no services subject to a <a href="#">deductible</a> on this plan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Are there other <a href="#">deductibles</a> for specific services?              | No                                                                                                                                                                                     | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$1,850 individual / \$3,700 family                                                                                                                                                    | 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 limits</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="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                                           | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. Visit <a href="http://www.multiplan.com/sbmaspecificservices">www.multiplan.com/sbmaspecificservices</a> or call 1-800-457-1309 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No                                                                                                                                                                                     | You don't need a <a href="#">referral</a> to see a <a href="#">specialist</a> 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                 |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                                                              | Primary care visit to treat an injury or illness        | \$25 <a href="#">copayment</a>               | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                     | <a href="#">Specialist</a> visit                        | \$25 <a href="#">copayment</a>               | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                     | <a href="#">Preventive care/screening/</a> immunization | No charge                                    | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. Preventive care benefits may be subject to limitations.                                                                                                                                                               |
| If you have a test                                                                                                                                                                                                                                  | <a href="#">Diagnostic test</a> (x-ray, blood work)     | \$50 <a href="#">copayment</a>               | Not covered                                        | No coverage for outpatient services provided at a hospital, drug testing, allergy testing, genetic testing or pathology.                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                     | Imaging (CT/PET scans, MRIs)                            | Not covered                                  | Not covered                                        | Not covered                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://member.procarerx.com/account/register">https://member.procarerx.com/account/register</a> | Tier 1                                                  | \$15 <a href="#">copayment</a>               | Not covered                                        | Coverage is limited to the formulary drug list. You may view the list by visiting <a href="https://www.sbmabenefits.com/purerx-standard/">https://www.sbmabenefits.com/purerx-standard/</a> . No coverage for non-preferred and <a href="#">specialty drugs</a> . Preventive medications are covered at no cost to the covered person as required by applicable law but may be subject to coverage limitations. |
|                                                                                                                                                                                                                                                     | Tier 2                                                  | \$30 <a href="#">copayment</a>               | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                     | Tier 3                                                  | \$50 <a href="#">copayment</a>               | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                     | Tier 4                                                  | \$75 <a href="#">copayment</a>               | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                 |
| If you have outpatient surgery                                                                                                                                                                                                                      | Facility fee (e.g., ambulatory surgery center)          | Not covered                                  | Not covered                                        | Not covered                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                     | Physician/surgeon fees                                  | Not covered                                  | Not covered                                        | Not covered                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you need immediate medical attention                                                                                                                                                                                                             | <a href="#">Emergency room care</a>                     | Not covered                                  | Not covered                                        | Not covered                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                     | <a href="#">Emergency medical transportation</a>        | Not covered                                  | Not covered                                        | Not covered                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                     | <a href="#">Urgent care</a>                             | \$50 <a href="#">copayment</a>               | Not covered                                        | Not covered                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you have a hospital stay                                                                                                                                                                                                                         | Facility fee (e.g., hospital room)                      | Not covered                                  | Not covered                                        | Not covered                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                     | Physician/surgeon fees                                  | Not covered                                  | Not covered                                        | Not covered                                                                                                                                                                                                                                                                                                                                                                                                     |

\*For more information about limitations and exceptions, call 1-888 505-7724.

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information |
|----------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                                                                  |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | Not covered                                  | Not covered                                        | Not covered                                            |
|                                                                                  | Inpatient services                        | Not covered                                  | Not covered                                        | Not covered                                            |
| <b>If you are pregnant</b>                                                       | Office visits                             | \$25 <a href="#">copayment</a>               | Not covered                                        | None                                                   |
|                                                                                  | Childbirth/delivery professional services | Not covered                                  | Not covered                                        | Not covered                                            |
|                                                                                  | Childbirth/delivery facility services     | Not covered                                  | Not covered                                        | Not covered                                            |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | Not covered                                  | Not covered                                        | Not covered                                            |
|                                                                                  | <a href="#">Rehabilitation services</a>   | Not covered                                  | Not covered                                        | Not covered                                            |
|                                                                                  | <a href="#">Habilitation services</a>     | Not covered                                  | Not covered                                        | Not covered                                            |
|                                                                                  | <a href="#">Skilled nursing care</a>      | Not covered                                  | Not covered                                        | Not covered                                            |
|                                                                                  | <a href="#">Durable medical equipment</a> | Not covered                                  | Not covered                                        | Not covered                                            |
|                                                                                  | <a href="#">Hospice services</a>          | Not covered                                  | Not covered                                        | Not covered                                            |
| <b>If your child needs dental or eye care</b>                                    | 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                                            |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)                                                  |                                                                                                                                                                                                                               |                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> <li>• Care when traveling outside the United States</li> <li>• Chemotherapy / Radiation Therapy</li> <li>• Chiropractic Care</li> </ul> | <ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care</li> <li>• Dialysis</li> <li>• Experimental / Investigational Treatments</li> <li>• Hearing Aids</li> <li>• Infertility Treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Long-Term Care</li> <li>• Private-Duty Nursing</li> <li>• Routine Eye Care</li> <li>• Transplant Services</li> <li>• Weight Loss Programs/Drugs</li> </ul> |

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

- None

**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](http://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](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: 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? No**

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 1-888-505-7724.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-505-7724.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-505-7724.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-505-7724.

Additional language services are available upon request. For more information, please contact the plan administrator at 1-888-505-7724.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$25 |
| ■ <a href="#">Diagnostic tests copayment</a>                    | \$50 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | N/A  |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$400          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$9,500        |
| <b>The total Peg would pay is</b> | <b>\$9,900</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> | \$0  |
| ■ Primary care <a href="#">copayment</a>                        | \$25 |
| ■ <a href="#">Diagnostic tests copayment</a>                    | \$50 |
| ■ <a href="#">Specialty drugs</a>                               | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$300          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$4,400        |
| <b>The total Joe would pay is</b> | <b>\$4,700</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |     |
|-----------------------------------------------------------------|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Emergency room care</a>                           | N/A |
| ■ <a href="#">Durable medical equipment</a>                     | N/A |
| ■ <a href="#">Rehabilitation services</a>                       | N/A |

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> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$0            |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$2,800        |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

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