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 1-888-385-2699. 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 1-800-393-1770 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$5,000 Individual / $6,000 Family**	Generally, you must pay all of the costs from providers up to the deductible amount before a plan begins to pay. This plan does not have a deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services delivered through a participating physician's office or other providers 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	
What is the out-of-pocket limit for this plan?	**Participating Providers:** $6,650 Individual / $13,300 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?	Not Applicable	This plan does not put a limit on your out-of-pocket costs.
Will you pay less if you use a network provider?	Yes. See www.multiplan.com or call 1-800-922- 4362 for a list of network providers.	This plan uses a provider network. This plan **does not cover** services or supplies provided by an out-of-network provider. Non-covered services and supplies provided by a network provider will be entitled to the network discount.
Do you need a referral to see a specialist?	No	

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	$20 Copay After Deductible	Not Covered	Max of 3 visits Per Plan Year
	Virtual Primary Care	$0 Copay		Unlimited Use
	Specialist visit	$50 Copay After Deductible	Not Covered	Max of 3 visits Per Plan Year
	Preventive care/screening/ immunization	No Charge – 100% Covered	Not Covered	No out-of-pocket costs for preventive care services provided by a network provider.
If you have a test	Diagnostic test (x-ray, blood work)	$50 Copay by Date of Service After Deductible	Not Covered	*Tests or exams performed as a preventive screening (for instance, a blood test as part of an annual adult physical wellness exam) are covered at 100% with no cost sharing.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	
If you need drugs to treat your illness or condition	Generic drugs	Preventive* – 100% Covered All Others – Not Covered	Not Covered	*Certain drugs required as part of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force, as required by the ACA are covered at 100% with no cost sharing. These recommendations may be found at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.
	Preferred brand drugs	Preventive* – 100% Covered All Others – Not Covered	Not Covered	
	Tier 1 Formulary:	$0 Copay	Not Covered	
	Tier 2 Formulary:	Under $14.95 Copay	Not Covered	
	Non-Formulary	Discount Only	Not Covered	
	Diabetic Supplies	Discount Only	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	
	Physician/surgeon fees	Not Covered	Not Covered	
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	
	Emergency medical transportation	Not Covered	Not Covered	
	Virtual Urgent Care	$0 Copay		Unlimited Use
	Urgent care facility	$50 Copay After Deductible	Not Covered	Max of 3 visits Per Plan Year
jhjlf you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	
	Physician/surgeon fees	Not Covered	Not Covered	
If you need mental health, behavioral health, or substance abuse services	**Virtual** Mental and Behavioral Health	$0 Copay	Not Applicable	Unlimited Use
	Outpatient services	Not Covered	Not Covered	
	Inpatient services	Not Covered	Not Covered	
If you are pregnant	Office visits	Not Covered*	Not Covered	*Certain women's preventive services as recommended by the Health Resources & Services Administration as required by the ACA are covered at 100% with no cost sharing. These recommendations may be found at: https://www.hrsa.gov/womens-guidelines/index.html.
	Childbirth/delivery professional services	Not Covered	Not Covered	
	Childbirth/delivery facility services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	
	Rehabilitation services	Not Covered	Not Covered	
	Habilitation services	Not Covered	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document.

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)	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	Not Covered	Not Covered	
	Hospice services	Not Covered	Not Covered	
If your child needs dental or eye care	Children's eye exam	No Charge – 100% Covered	Not Covered	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	No Charge – 100% 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.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Hospital In-Patient/Out-patient services
- Long-term care
- Private-duty nursing
- Hearing Aids
- Routine eye care (Adult)
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The federal agency that administers COBRA is the United States Department of Labor at 1-866-444-3272. 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 1-888-385-2699.

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 1-800-393-1770.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag SA 1-800-393-1770.

* For more information about limitations and exceptions, see the plan or policy document.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-393-1770.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-393-1770.

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** **$0**
- **Specialist copayment** **Not Covered**
- **Hospital (facility) coinsurance** **Not Covered**
- **Other coinsurance** **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	N/A
Copayments	NA
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$12,700
The total Peg would pay is	**$12,700**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **Not Covered**
- **Hospital (facility) coinsurance** **Not Covered**
- **Other coinsurance** **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	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$5,600
The total Joe would pay is	**$5,600**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **Not Covered**
- **Hospital (facility) coinsurance** **Not Covered**
- **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	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	$2,800
The total Mia would pay is	**$2,800**

* For more information about limitations and exceptions, see the plan or policy document.

The plan would be responsible for designated preventive services only.