



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 1-866-417-4240. 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 1-866-417-4240 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$300 person / \$900 family. If 2 or more family members are in a common accident, only one deductible will apply.	Generally, you must pay all of the costs from provider 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. Covered preventive care services provided by a Preferred Provider.	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?	Yes. \$100/ preferred hospital and \$300/ non-preferred hospital per admission.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Tier I Medical: \$1,000 person. Tier II Medical: \$2,000 person / \$4,000 family (includes deductibles and in network coinsurance) Prescription Drugs: \$2,000 person / \$4,000 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-billed charges, deductibles (Tier 1 only), Prescription Drugs (Tier 1 only) durable medical equipment (Tier 1 only), artificial limbs and implanted devices (Tier 1 only), the difference between the Medicare allowable cost and the amount charged by the provider for medical services received from a provider who does not participate in Medicare, expenses that are not covered by Medicare and health care this plan doesn't cover.	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?	Yes. Medicare providers who accept Medicare assignment.	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

Important Questions	Answers	Why This Matters:
		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 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		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% coinsurance	20% coinsurance of Allowed Amount	Deductible and coinsurance waived for Teladoc visits. Chiropractic care limited to 25 visits annually. Nutritionist, 4 visit and only with diagnosis of pulmonary or cardiac disease. Massage limited to 10 visits per year. Acupuncture limited to 10 visit per year. Diabetes Education limited to once per lifetime. Preventive care is defined in accordance with Federal Regulations. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	Specialist visit			
	Preventive care/screening /immunization	No Charge Deductible does not apply.	20% coinsurance of Allowed Amount	
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance of Allowed Amount	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com.	Generic drugs	Retail: 20% coinsurance /prescription Mail: \$10 copay /prescription.		Prescription Benefits provided through SilverScript Employer PDP. Covers up to a 34-day supply for a retail prescription and up to a 90-day supply for a mail order prescription. For brand drugs, when a generic is available, the plan pays cost of generic equivalent. Specialty drugs are limited to one fill (30-day supply) per month. New to market Specialty drugs will
	Preferred brand drugs	Retail: 20% coinsurance /prescription Mail: \$30 copay /prescription		
	Non-preferred brand drugs	Retail: 30% coinsurance /prescription Mail: \$50 copay /prescription		
	Specialty drugs	Same as generic/brand benefit		

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)	
				receive clinical review and require <u>preauthorization</u> . No coverage for drugs available without physician's prescription (except insulin). Non-formulary drugs may not be covered without approval through the preauthorization process. To review preferred <u>prescription drugs</u> , see the formulary at www.caremark.com .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u> of <u>Allowed Amount</u>	<u>Preauthorization</u> is required, the <u>Plan</u> may disallow charges if <u>preauthorization</u> is not obtained. Orthognathic surgery only covered for dependent children.
	Physician/surgeon fees			None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> of <u>Allowed Amount</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> of <u>Allowed Amount</u>	Must show medical necessity. Transportation to nearest facility.
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> of <u>Allowed Amount</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u> of <u>Allowed Amount</u>	<u>Preauthorization</u> is required, the <u>Plan</u> may disallow charges if <u>preauthorization</u> is not obtained.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u> of <u>Allowed Amount</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> of <u>Allowed Amount</u>	None
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> of <u>Allowed Amount</u>	Care must be provided at an approved treatment facility. Inpatient stays require <u>preauthorization</u> , the <u>Plan</u> may disallow charges if <u>preauthorization</u> is not obtained.
If you are pregnant	Office visits	20% <u>coinsurance</u>	20% <u>coinsurance</u> of <u>Allowed Amount</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services a <u>coinsurance</u> may apply.

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)	
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance of Allowed Amount	No coverage of dependent child except ACA preventive services
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance of Allowed Amount	Licensed birthing facility charges only to extent charges would have been incurred at hospital. No coverage of dependent child except ACA preventive services.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance of Allowed Amount	Physician certification required.
	Rehabilitation services	20% coinsurance	20% coinsurance of Allowed Amount	To correct the effect of illness or injury. ECG-monitored exercise limited to 12 weeks.
	Habilitation services	20% coinsurance	20% coinsurance of Allowed Amount	Coverage limited to the care rendered for congenital, developmental or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development. The Plan also covers habilitative therapy services for autism spectrum and other disorders classified in the current International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) as mental disorders.
	Skilled nursing care	20% coinsurance	20% coinsurance of Allowed Amount	Maximum of 70 days, provided hospitalized at least 5 days and admitted to skilled nursing care within 14 days.
	Durable medical equipment	20% coinsurance	20% coinsurance of Allowed Amount	None.
	Hospice services	20% coinsurance	20% coinsurance of Allowed Amount	Certified fewer than 6 months to live.

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](#).)

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|--|---|----------------------------------|
| • Bariatric surgery | • Cosmetic Surgery (except to repair injury or congenital defect) | • Infertility treatment |
| • Benefits when Medicare is or could be primary (This exclusion applies if you are eligible to enroll in Medicare, but fail to do so.) | • Expenses resulting from work related conditions | • Long-term care |
| | | • Routine foot care |
| | | • Weight Loss Programs |
| | | • Work related injury or illness |

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

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|---------------------|--|---|
| • Acupuncture | • Hearing Aids | • Private-Duty Nursing (if <u>medically necessary</u>) |
| • Chiropractic Care | • Non-emergency care when traveling outside the U.S. | • Routine Eye Care (Adult) |

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-EBSA (3272) or www.dol.gov/ebsa/healthreform and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Trust Administration Office at 1-866-417-4240.

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 1-866-417-4240.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-417-4240.

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	\$300
■ Specialist coinsurance	20%
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,360

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$300
■ Specialist coinsurance	20%
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

■ The plan's overall deductible	\$300
■ Specialist coinsurance	20%
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$800

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