The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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: Personify Health at 800-849-0580. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>www.dol.gov.ebsa/healthreform</u> or call 800-849-0580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,200/Individual \$2,400/Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services   Vest preventive services office visits and   amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, the		
Are there other deductibles for specific services?	Yes, \$150 for non-generic prescription drugs.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. If you have other family members on the <u>plan</u> , this <u>deductible</u> applies to the family not each individual.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$3,250/Individual \$6,500/Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own individual <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limits</u> have been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, health care this plan doesn't cover and cost containment penalties for failure to obtain pre-authorization when required.	Even though you pay these expenses, they don't count toward the out-of-pocket limits.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Not applicable	This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any <u>provider</u> . If you receive a bill from a <u>provider</u> for the difference between billed charges and the amount payable by the <u>plan</u> that is more than your <u>cost-sharing</u> amount under the <u>plan</u> , please call Personify Health at 800-849-0580.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25/visit <u>Deductible</u> waived	Services may also be available through Teladoc at no charge. Call 1-800-Teladoc or visit <a href="https://www.teladoc.com">www.teladoc.com</a>
	Specialist visit	\$35/visit <u>Deductible</u> waived	
	Preventive care/screening/ immunization	No charge	None
	Diagnostic test (x-ray, blood work)  Quest Lab No charge Other lab 20% coinsurance	No charge Other lab	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	US Imaging may be able to refer you to a facility that will result in no cost to you. Contact US Imaging at 877-874-6385.  Pre-authorization required for certain imaging. Benefit may be reduced if pre-authorization is not obtained.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Generic drugs	Retail \$10/prescription  Mail Order \$25/prescription	\$150 deductible applies to non-generic drugs.  All retail & mail order prescription drugs
If you need drugs to treat your illness or condition  More information about prescription drug	Preferred brand drugs	Retail \$30/prescription  Mail Order \$75/prescription	must be obtained through a participating Express Scripts pharmacy.  Retail: Up to 30-day supply per
coverage is available at www.customercare@rxb enefits.com	Non-preferred brand drugs	Retail \$50/prescription Mail Order	copayment. 31-90 day supply available for 2 ½ times Retail copayment.  Mail Order: Up to 90-day supply per
	Specialty drugs	\$125/prescription  30% of the prescription maximum allowed amount up to a maximum copayment of \$150/prescription	copayment  Must be obtained through Accredo. Call 800-922-8279.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Pre-authorization required for certain procedures. Benefit may be reduced if pre-authorization is not obtained.
	Physician/surgeon fees	20% <u>coinsurance</u>	None
	Emergency room care	\$200/visit + 20% coinsurance	Copayment waived if admitted to hospital.
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	None
	Urgent care	\$75/visit <u>Deductible</u> waived	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Limited to semi-private room rate.  Pre-authorization required. Benefit may be reduced if pre-authorization is not obtained.
	Physician/surgeon fees	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office \$25/visit  Deductible waived  Outpatient facility 20% coinsurance	Services may also be available through Teladoc at no charge. Call 1-800-Teladoc or visit <a href="www.teladoc.com">www.teladoc.com</a> . <a href="Pre-authorization">Pre-authorization</a> required for certain services. Benefit may be reduced if <a href="pre-authorization">pre-authorization</a> is not obtained.
	Inpatient services	20% coinsurance	Limited to semi-private room rate.  Pre-authorization required. Benefit may be reduced if pre-authorization is not obtained.
If you are pregnant	Office visits	No charge	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	Pre-authorization is only required for stay exceeding 48 hours (or 96 hours after C-section.) When required, benefit may be reduced if pre-authorization is not obtained.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Home health care	20% coinsurance	Limited to 100 visits per Calendar Year.  Pre-authorization required. Benefit may be reduced if pre-authorization is not obtained.
	Rehabilitation services	20% coinsurance	Limited to 60 visits per Calendar Year combined for Physical, Occupational and Speech therapy. Limits for habilitation
If you need help recovering or have other special health needs	Habilitation services	20% coinsurance	services do not apply to autism spectrum disorders.
	Skilled nursing care	20% coinsurance	Limited to 100 days per Calendar Year.  Pre-authorization required. Benefit may be reduced if pre-authorization is not obtained.
	Durable medical equipment	20% coinsurance	Pre-authorization required for certain durable medical equipment. Benefit may be reduced if pre-authorization is not obtained.
	Hospice services	<u>Deductible</u> only	Includes 10 days respite care.
If your child needs dental or eye care	Children's eye exam	No charge	Limited to one exam every three years.
	Children's glasses	Not covered	Must enroll in separate vision plan.
	Children's dental check-up	Not covered	Must enroll in separate dental plan.

#### **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)

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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

- Acupuncture (Limited to 30 visits per Calendar Year)
- Bariatric surgery (Limited to treatment of morbid Hearing aids (Limited to \$4,000 every 36 obesity)
- Chiropractic care (Limited to 30 visits per Calendar Year)
  - months)
  - Infertility treatment (Limited to \$80,000 lifetime medical and Rx combined)
- Routine eye care (One exam every three years under age 40; one exam annually age 40 & over)
- Weight loss programs (Limited to treatment of morbid obesity)

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: Personify Health at 800-849-0580 and the Department of Labor, Employee Benefits Security Administration at 866-444-EBSA (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: Personify Health at 800-849-0580 and the Department of Labor, Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

#### 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 800-849-0580.

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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> Med+Rx <u>deductible</u>	\$1,350
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
Other (tests) 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	
In this example, Peg would pay:		
Cost Sharing		
<u>Deductibles</u>	\$1,200	
<u>Copayments</u>	\$0	
Coinsurance	\$2,100	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$3,360	

# Managing Joe's Type 2 Diabetes

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

■ The plan's Med+Rx deductible	\$1,35
■ Specialist copayment	\$2
■ Hospital (facility) coinsurance	20%
■ Other (brand name drugs) <u>copaymer</u>	<u>ıt</u> \$3

#### This EXAMPLE event includes services like:

<u>Primary care physician</u> 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		
<u>Deductibles</u>	\$1,100	
Copayments	\$800	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,920	

# **Mia's Simple Fracture**

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

The <u>plan's</u> Med+Rx <u>deductible</u>	\$1,350
Specialist copayment	\$25

■ Hospital(ER)copay+coinsurance \$200+20%

Other <u>coinsurance</u>

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	
<u>Deductibles</u>	\$1,200
Copayments	\$200
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600

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