



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 800-701-8992. 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 800-701-8992 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$4,000 individual/ \$8,000 family for Preferred Network. \$8,000 individual/ \$16,000 family for Out-of-Network.	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 covered before you meet your <u>deductible</u> ?	Yes. Breast pumps, Cologuard preventive, flu shots and immunizations for all Networks. Preventive care & services for Preferred Network.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No. There are no other specific <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$8,000 individual/ \$16,000 family for Preferred Network. Includes pharmacy. \$15,000 individual/ \$30,000 family for Out-of-Network.	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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Penalties, ineligible charges, premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.accesshma.com or call 1-833-865-0141 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (balance billing). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> 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
		Preferred 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	30% coinsurance	50% coinsurance	—————none—————
	Specialist visit	30% coinsurance	50% coinsurance	—————none—————
	Preventive care/screening/immunization	No charge, deductible does not apply	Not covered	Out-of-Network breast pumps, flu shots and immunizations are covered at no charge, deductible does not apply. 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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Pre-authorization is recommended for advanced outpatient imaging procedures for MRI of the head, brain, spine or joints and CT scan of the chest, abdomen, pelvis, or joints.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.optumrx.com	Generic drugs	\$10 copay for retail for 1 to 30 days; \$25 copay for retail for 31 to 90 days; \$25 copay for mail order		Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	\$40 copay for retail for 1 to 30 days; \$100 copay for retail for 31 to 90 days; \$100 copay for mail order		
	Non-preferred brand drugs	\$80 copay for retail for 1 to 30 days; \$200 copay for retail for 31 to 90 days; \$200 copay for mail order		
	Specialty drugs	\$100 copay		Please contact OptumRx, your specialty pharmacy, for more information on what is covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred 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)	30% coinsurance	50% coinsurance	Preauthorization is required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	—————none—————
If you need immediate medical attention	Emergency room care	30% coinsurance		—————none—————
	Emergency medical transportation	30% coinsurance		—————none—————
	Urgent care	30% coinsurance	50% coinsurance	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization is required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Preauthorization is required for partial hospitalization and intensive outpatient.
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization is required. Residential treatment is covered.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	—————none—————
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be preauthorized at the time your provider recommends the extended stay.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Preauthorization is required. Limited to a 60-visit calendar year maximum.
	Rehabilitation services	30% coinsurance	50% coinsurance	Preauthorization is required for inpatient and limited to a 60-day calendar year maximum (combined with skilled nursing facility). Outpatient is limited to a 45-visit calendar year maximum. Swim therapy is covered.
	Habilitation services	30% coinsurance	50% coinsurance	Habilitation services, including neurodevelopmental therapy and rehabilitative therapies for the treatment of autism, are covered under the Outpatient Rehabilitation Services benefit. Limited to a separate 60-visit calendar year maximum.
	Skilled nursing care	30% coinsurance	50% coinsurance	Preauthorization is required. Limited to a 60-day calendar year maximum (combined with inpatient rehabilitation).
	Durable medical equipment	30% coinsurance	50% coinsurance	Preauthorization is required for equipment over \$2,000.
	Hospice services	30% coinsurance	50% coinsurance	Preauthorization is required. Limited to a 360-day lifetime maximum. Respite care is limited to 4 hours per week.
If your child needs dental or eye care	Children's eye exam	Not covered		Please contact vision benefit administrator.
	Children's glasses	Not covered		Please contact vision benefit administrator.
	Children's dental check-up	Not covered		Please contact dental benefit administrator.

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 .)		
<ul style="list-style-type: none">• Cosmetic surgery• Dental care (Adult)• Hearing aids• Infertility treatment (unless required to treat or correct underlying causes of infertility)	<ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S.• Private-duty nursing	<ul style="list-style-type: none">• Routine eye care (Adult)• Routine foot care (except if medically necessary)• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Acupuncture	<ul style="list-style-type: none">• Bariatric surgery (medically necessary)	<ul style="list-style-type: none">• Chiropractic care (20-visit yearly limit)

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: Reformed Benefits Association (RBA), 800-701-8992, 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 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: 1-833-865-0141, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-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 1-833-865-0141.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-865-0141.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-833-865-0141.]

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-865-0141.]

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	\$4,000
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$4,000
Copayments	\$10
Coinsurance	\$2,570
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,640

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$4,000
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$4,000
Copayments	\$140
Coinsurance	\$40
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$4,200

Mia's Simple Fracture

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

■ The plan's overall deductible	\$4,000
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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	\$2,800
Copayments	\$00
Coinsurance	\$00
What isn't covered	
Limits or exclusions	\$00
The total Mia would pay is	\$2,800