**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 deductible?** | **$8,000** individual/**$16,000** family for Preferred Network.<br>**$12,000** individual/**$20,000** family for Out-of-Network. | Generally, you must pay all of the costs from providers 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.** Breast pumps, Cologuard preventive, flu shots and immunizations for all Networks. Preventive care & services for Preferred Network. | 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.** There are no other specific deductibles. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$8,000** individual/**$16,000** family for Preferred Network. Includes pharmacy.<br>**$15,000** individual/**$30,000** family for Out-of-Network. | 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?** | 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 out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.accesshma.com or call 1-833-865-0141 for a list of network providers. | 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 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 |
|---|---|---|---|---|
| | | 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 | No charge | 50% coinsurance | ————none———— |
| | Specialist visit | No charge | 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) | No charge | 50% coinsurance | ————none———— |
| | Imaging (CT/PET scans, MRIs) | No charge | 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. |

| 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 drugs to treat your illness or condition** More information about **prescription drug coverage** is available at https://www.optumrx.com | Generic drugs | No charge, after deductible for retail and 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 | No charge, after deductible for retail and mail order | | |
| | Non-preferred brand drugs | No charge, after deductible for retail and mail order | | |
| | Specialty drugs | No charge, after deductible | | Please contact OptumRx, your specialty pharmacy, for more information on what is covered. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | 50% coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | No charge | 50% coinsurance | ————none———— |
| **If you need immediate medical attention** | Emergency room care | No charge | | ————none———— |
| | Emergency medical transportation | No charge | | ————none———— |
| | Urgent care | No charge | 50% coinsurance | ————none———— |

| 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 a hospital stay** | Facility fee (e.g., hospital room) | No charge | 50% coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | No charge | 50% coinsurance | ————none———— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | 50% coinsurance | Preauthorization is required for partial hospitalization and intensive outpatient. |
| | Inpatient services | No charge | 50% coinsurance | Preauthorization is required. Residential treatment is covered. |
| **If you are pregnant** | Office visits | No charge | 50% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| | Childbirth/delivery professional services | No charge | 50% coinsurance | ————none———— |
| | Childbirth/delivery facility services | No charge | 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. |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 50% coinsurance | Preauthorization is required. Limited to a 60-visit calendar year maximum. |
| | Rehabilitation services | No charge | 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. |

[* For more information about limitations and exceptions, see the plan or policy document at https://reformedbenefits.org/ .]

| 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) | |
| | Habilitation services | No charge | 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 | No charge | 50% coinsurance | Preauthorization is required. Limited to a 60-day calendar year maximum (combined with inpatient rehabilitation). |
| | Durable medical equipment | No charge | 50% coinsurance | Preauthorization is required for equipment over $2,000. |
| | Hospice services | No charge | 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.)**

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment (unless required to treat or correct underlying causes of infertility)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (except if medically necessary)
- Weight loss programs

[* For more information about limitations and exceptions, see the plan or policy document at https://reformedbenefits.org/ .]

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture | • Bariatric surgery (medically necessary) | • 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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-865-0141.]

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

[* For more information about limitations and exceptions, see the plan or policy document at https://reformedbenefits.org/ .]

## 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** | **$8,000** |
| **Specialist coinsurance** | **00%** |
| **Hospital (facility) coinsurance** | **00%** |
| **Other coinsurance** | **00%** |

**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 | $8,000 |
| Copayments | $00 |
| Coinsurance | $00 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$8,060** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$8,000** |
| **Specialist coinsurance** | **00%** |
| **Hospital (facility) coinsurance** | **00%** |
| **Other coinsurance** | **00%** |

**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 | $5,190 |
| Copayments | $00 |
| Coinsurance | $00 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$5,210** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$8,000** |
| **Specialist coinsurance** | **00%** |
| **Hospital (facility) coinsurance** | **00%** |
| **Other coinsurance** | **00%** |

**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** |

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