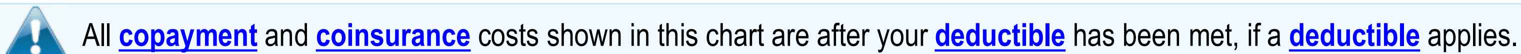
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-522-4161 (TTY: 711). 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 1-800-522-4161 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Event chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Prescription drug coverage and in-network dental and vision care are covered without any deductibles.	The plan covers Prescription drug coverage and in-network dental and vision care without any deductibles.
Are there other deductibles for specific services?	Yes. Out-of-network Dental: $15/individual. There are no other specific calendar year deductibles.	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?	**$250** individual (prescription drug coverage)	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums 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.express-scripts.com or call 1-800-522-4161 (TTY: 711) for a list of network providers.	This plan uses a provider network and there is no coverage for out-of-network prescription drugs. You will pay less if you use a provider in the plan's network for prescription drugs, vision and dental services. 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). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	Not applicable because there are no specialists for prescription drugs.


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	Not covered	Not covered	No coverage is available.
	Specialist visit	Not covered	Not covered	No coverage is available.
	Preventive care/screening/ immunization	Not covered	Not covered	No coverage is available.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	No coverage is available.
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$5 copay/prescription (retail) $10 copay/prescription (mail order)	Not covered	Covers up to a 34-day supply/100 pills (retail); 90-day supply of maintenance medications (mail order or mail at retail).
	Preferred brand drugs	$15 copay/prescription (retail) $30 copay/ prescription (mail order)	Not covered	
	Non-preferred brand drugs	$30 copay/prescription (retail) $60 copay/prescription (mail order)	Not covered	
	Specialty drugs	$5/$15/$30 copays (retail)	Not covered	Covers up to a 34-day supply/100 pills. Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	No coverage is available.
	Physician/surgeon fees	Not covered	Not covered	No coverage is available.
If you need immediate medical attention	Emergency room care	Not covered	Not covered	No coverage is available.
	Emergency medical transportation	Not covered	Not covered	No coverage is available.
	Urgent care	Not covered	Not covered	No coverage is available.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	No coverage is available.

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)	
	Physician/surgeon fees	Not covered	Not covered	No coverage is available.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	No coverage is available.
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	Not covered	Not covered	No coverage is available.
	Childbirth/delivery professional services	Not covered	Not covered	No coverage is available.
	Childbirth/delivery facility services	Not covered	Not covered	No coverage is available.
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	No coverage is available.
	Rehabilitation services	Not covered	Not covered	No coverage is available.
	Habilitation services	Not covered	Not covered	No coverage is available.
	Skilled nursing care	Not covered	Not covered	No coverage is available.
	Durable medical equipment	Not covered	Not covered	No coverage is available.
	Hospice services	Not covered	Not covered	No coverage is available.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage is available.
	Children's glasses	Not covered	Not covered	No coverage is available.
	Children's dental check-up	Not covered	Not covered	No coverage is available.

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.)		
• Acupuncture • Bariatric surgery • Chiropractic care • Cosmetic surgery	• Coverage outside the United States • Hearing aids • Infertility treatment • Long-term care	• Medical coverage • Private-duty nursing • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• Dental care ($2,500 annual Maximum) • 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. 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 the Plan at 1-800-522-4161 (TTY: 711). You may also contact 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 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 1-800-522-4161 (TTY: 711).

——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** **N/A**
- **Specialist copayment** **N/A**
- **Hospital (facility) coinsurance** **N/A**
- **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	$0
Copayments	$10
Coinsurance	$0
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** **N/A**
- **Specialist copayment** **N/A**
- **Hospital (facility) coinsurance** **N/A**
- **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	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,100
The total Joe would pay is	**$2,300**

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

- **The plan's overall deductible** **N/A**
- **Specialist copayment** **N/A**
- **Hospital (facility) coinsurance** **N/A**
- **Other coinsurance** **N/A**

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	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,800
The total Mia would pay is	**$2,800**

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