




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 Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	No	Not applicable because there is neither an overall deductible nor any services available under the Medical Plan .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific 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 .
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.)

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$2,800
The total Mia would pay is	\$2,800