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, [insert contact information]. 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 call 1-855-375-7125 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	network and out-of-network providers: $0 Individual / $0 Family Benefit Period: Per Plan year.	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 meet the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care , Prescription Drug and Physician services are covered before you meet your deductible.	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	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	network and out-of-network providers: $7,350 individual / $14,700 family;	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?	Premiums, balance-billing charges, penalties for failure to obtain Preauthorization, ,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?	No. It is an open access plan. However, the plan does provide a physician network through the Prime Health Services Network. A list of network providers can be found at https://uhppon.primehealthservices.com/ or call 1-866.348.3887.	This plan is an open access plan
Do you need a referral to see a specialist?	No	You can see a specialist you choose without a referral

[* For more information about limitations and exceptions, contact 1-855-375-7125

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	$25 co-pay	$25 co-pay	Limit 10 visits per Plan Year
	Specialist visit	$50 co-pay	$50 co-pay	Limit 10 visits per Plan Year
	Preventive care/screening/ immunization	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$50 co-pay		Limit 3 visits per Plan Year for Lab services. Combined Limit of 3 visits for X-Ray and Imaging.
	Imaging (CT/PET scans, MRIs)	$50 co-pay		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 877-226-2378.	Generic drugs	$10 co-pay Retail $20 co-pay Mail Order	Not Covered	All Tiers. Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	20% co-insurance	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 co-pay		Limit 1 surgery per Plan Year
	Physician/surgeon fees	$50 co-pay	$50 co-pay	----------None----------
If you need immediate medical attention	Emergency room care	$350 co-pay		All facilities are covered as in-network subject to meeting "emergency" criteria. co-pay is waived if inpatient admission. Limit 1 ER visit per Plan Year
	Emergency medical transportation	Not Covered		None
	Urgent care	$50 co-pay	$50 co-pay	Limit 2 visits per Plan Year
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 co-pay		Limit 5 Inpatient days per Plan Year for all Inpatient services.
	Physician/surgeon fees			

[* For more information about limitations and exceptions, contact 1-855-375-7125

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$25 co-pay	$25 co-pay	Refer to SPD for covered services for ABA Therapy. Limit 8 visits per Plan Year.
	Inpatient services	$350 co-pay		----------None----------
If you are pregnant	Office visits	$25 co-pay / 1st Visit	$25 co-pay / 1st Visit	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$350 co-pay		----------None----------
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	$25 co-pay	$25 co-pay	Limit 10 visits per Plan Year
	Rehabilitation services	Not Covered	Not Covered	----------None----------
	Habilitation services	Not Covered	Not Covered	----------None----------
	Skilled nursing care	Not Covered		----------None----------
	Durable medical equipment	Not Covered		----------None----------
	Hospice services	Not Covered		----------None----------
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

[* For more information about limitations and exceptions, contact 1-855-375-7125

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	• Cosmetic Surgery
• Hearing Aids	• Long-Term Care	• Non-Emergency Care outside US
• Routine Dental Care	• Routine Eye Care	• Routine Foot Care
• Weight Loss Programs	• Chiropractic Care	• Chemotherapy

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

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: 1-866-444-3272 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: 1-855-375-7125.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-855-375-7125

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-375-7125.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-375-7125.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-375-7125.

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, contact 1-855-375-7125

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** **$0**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$350**
- **Other 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	**$13,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$550
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$550**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$350**
- **Other coinsurance** **20%**

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	**$4,110**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$40
What isn't covered	
Limits or exclusions	$1,290
The total Joe would pay is	**$1,430**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$350**
- **Other coinsurance** **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	**$2,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$830
The total Mia would pay is	**$1,230**

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