
 **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 888-701-2975. 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](http://www.dol.gov/ebsa/healthreform) or call 888-701-2975 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	N/A	See Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	N/A	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive care</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive</a> services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	N/A	This <a href="#">plan</a> does not have an out-of-pocket limit on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	N/A	This <a href="#">plan</a> does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.employersolutionsbenefits.com">www.employersolutionsbenefits.com</a> or call 888-701-2975 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ).
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">copayment</a>	Not Covered	None.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a>	Not Covered	None.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$60 <a href="#">copayment</a>	Not Covered	Labs in a clinic or independent lab setting are covered at no charge.
	Imaging (CT/PET scans, MRIs)	\$200 <a href="#">copayment</a>	Not Covered	None.
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.employersolutionsbenefits.com">www.employersolutionsbenefits.com</a>	Preventive Generic drugs	30-day supply Retail: No Charge 90-day supply Mail Order: No Charge		<a href="#">Cost sharing</a> does not apply for <a href="#">preventive Prescriptions</a> .
	Non-Preventive Generic drugs	30-day supply Retail: \$10 <a href="#">copayment/Prescription</a> 90-day supply Mail Order: Not Covered		
	Preferred brand drugs	30-day supply Retail: 100% Copay 90-day supply Mail Order: 100% Copay		
	Non-preferred Brand drugs	30-day supply Retail: Not Covered 90-day supply Mail Order: Not Covered		
	<a href="#">Specialty drugs</a>	30-day supply Retail & Mail Order: Not Covered		None.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	None.
	Physician/surgeon fees	Not Covered	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Not Covered	Not Covered	None.
	<a href="#">Emergency medical transportation</a>	Not Covered	Not Covered	None.
	<a href="#">Urgent care</a>	\$50 <a href="#">copayment</a>	Not Covered	None.
<b>If you have a hospital</b>	Facility fee (e.g., hospital room)	Not Covered	Not Covered	None.

\* For more information about limitations and exceptions, see the plan or policy document at [www.employersolutionsbenefits.com](http://www.employersolutionsbenefits.com).

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)	
stay	Physician/surgeon fees	Not Covered	Not Covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$75 <a href="#">copayment</a>	Not Covered	10 visit limit per year.
	Inpatient services	Not Covered	Not Covered	None.
If you are pregnant	Office visits	No Charge	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive</a> services. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	Not Covered	Not Covered	
	Childbirth/delivery facility services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Not Covered	Not Covered	None.
	<a href="#">Rehabilitation services</a>	Not Covered	Not Covered	None.
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	None.
	<a href="#">Skilled nursing care</a>	Not Covered	Not Covered	None.
	<a href="#">Durable medical equipment</a>	\$50 <a href="#">copayment</a>	Not Covered	None.
If your child needs dental or eye care	<a href="#">Hospice services</a>	Not Covered	Not Covered	None.
	Children's eye exam	No Charge	Not Covered	Limit of 1 routine exam per year.
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	None.

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Brand and Specialty Drugs</li> <li>Childbirth/Delivery services</li> <li>Chiropractic care</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Durable medical equipment</li> <li>Habilitation Services</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Home Health Care</li> <li>Hospital Stays</li> <li>Imaging (CT/PET scans, MRIs)</li> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Outpatient Surgery</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Rehabilitation Services</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> <li>Skilled Nursing Care</li> <li>Weight loss programs</li> </ul>

\* For more information about limitations and exceptions, see the plan or policy document at [www.employersolutionsbenefits.com](http://www.employersolutionsbenefits.com).

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Routine Eye Care (one exam/year)

**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](http://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](http://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: : Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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? 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 888-701-2975

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-701-2975

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-701-2975

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-701-2975

————— *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](#) \$50
- Hospital (facility) N/A
- Other N/A

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic test](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$11,100
<b>The total Peg would pay is</b>	<b>\$11,100</b>

**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](#) \$50
- Hospital (facility) N/A
- Other N/A

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- [Diagnostic test](#) (*blood work*)
- Prescription drugs
- [Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$350
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$3,100
<b>The total Joe would pay is</b>	<b>\$3,100</b>

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

- The [plan's](#) overall [deductible](#) N/A
- [Specialist Copayment](#) \$50
- Hospital (facility) N/A
- Other 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

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