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, please call 1.888.816.3096. 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. https://www.healthcare.gov/sbc-glossary or call 1.888.816.3096 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$750** Single/**$2,250** Family	Generally, you must pay all 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?	Deductible does not apply to ACA Preventive Care services or to services with a copayment.	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?	In-Network: **$5,000** Single/**$10,000** 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?	Penalties, **premiums**, **balance billing** 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?	This **Plan** includes access to the "Network" known as the PHCS Network for Value-Driven Health Plans. For a list of providers, please go to www.hstconnect.com or call 800.440.7427	This **plan** does use a **provider network** "PHCS Network for VDHP." However, you can receive covered services from any **provider**. If you receive a bill from a **provider** or **facility** for the difference between billed charges and the amount payable by the **plan** and is more than your **cost-sharing** amount under the **plan**, please contact The Health Plan 888.816.3096.
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 Network Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	None
	Specialist visit	$25 copay	None
	Preventive care/screening/ immunization	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)	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30 % coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com or call 1.800.334.8134	Generic drugs (Tier 1)	$5 copay/retail $10 copay/mail order	Prescription costs subject to the Medical Out-of-Pocket limit. Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge, deductible does not apply. Retail Pharmacy- 30-day supply Mail Order- 90-day supply Precertification is required for certain drugs.
	Preferred brand drugs (Tier 2)	$80 copay/retail $160 copay/mail order	
	Non-preferred brand drugs (Tier 3)	50% coinsurance/retail and mail order	
	Specialty drugs (Tier 4)	See applicable copays above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Precertification is required
	Physician/surgeon fees	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay, then 30% coinsurance, deductible does not apply	Emergency room copay is waived if admitted
	Emergency medical transportation	30% coinsurance	None
	Urgent care	$25 copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Precertification is required
	Physician/surgeon fees	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician office visit: $25 copay Outpatient: 30% coinsurance	None
	Inpatient services	30% coinsurance	Precertification is required
If you are pregnant	Office visits	$25 copay	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment, or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Precertification is required. Limited to 180 visits per calendar year
	Rehabilitation services	30% coinsurance	Precertification is required for inpatient services. Manipulation therapy is limited to 40 visits per calendar year.
	Habilitation services	30% coinsurance	None
	Skilled nursing care	30% coinsurance	Precertification is required
	Durable medical equipment	30% coinsurance	Precertification is required
	Hospice services	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	Covered under preventative care
	Children's glasses	Not covered	None
	Children's dental check-up	Not covered	None

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
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Infertility treatment
- Long-term care
- 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.)		
• Bariatric surgery • Chiropractic care	• Non-emergency care when traveling outside the U.S.	• Coverage provided outside the United States

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 or the Department of Health and Human Services at 1.877.267.2323 x61565 or www.cciio.cms.gov. 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 on how 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 Health Plan Appeals Coordinator at 1.888.816.3096 or 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 1.855.577.7123

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.855.577.7123

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1.855.577.7123

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1.855.577.7123

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	**$750**
Specialist coinsurance	**$25**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$750
Copayments	$10
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,320**

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

The plan's overall deductible	**$750**
Specialist coinsurance	**$25**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$750
Copayments	$1,400
Coinsurance	$50
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

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

The plan's overall deductible	**$750**
Specialist coinsurance	**$25**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$750
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,550**

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