




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](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 <b><u>deductible</u></b> ?	In-Network: <b>\$250 Single/\$500 Family</b>	Generally, you must pay all the costs from <b>providers</b> up to the <b><u>deductible</u></b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <b><u>deductible</u></b> until the total amount of <b><u>deductible</u></b> expenses paid by all family members meets the overall family <b><u>deductible</u></b> .
Are there services covered before you meet your <b><u>deductible</u></b> ?	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 <b><u>deductible</u></b> amount. But a <b><u>copayment</u></b> or <b><u>coinsurance</u></b> may apply. For example, this <b>plan</b> covers certain <b><u>preventive services</u></b> without <b><u>cost-sharing</u></b> and before you meet your <b><u>deductible</u></b> . See a list of covered <b><u>preventive services</u></b> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <b><u>deductibles</u></b> for specific services?	No.	You don't have to meet <b><u>deductibles</u></b> for specific services.
What is the <b><u>out-of-pocket limit</u></b> for this <b>plan</b> ?	In-Network: <b>\$1,500 Single/\$3,000 Family</b>	The <b><u>out-of-pocket limit</u></b> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> , they have to meet their own <b><u>out-of-pocket limits</u></b> until the overall family <b><u>out-of-pocket limit</u></b> has been met.
What is not included in the <b><u>out-of-pocket limit</u></b> ?	Penalties, <b><u>premiums</u></b> , <b><u>balance billing</u></b> charges, and health care this <b>plan</b> doesn't cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
Will you pay less if you use a <b><u>network provider</u></b> ?	This <b>Plan</b> includes access to the "Network" known as the PHCS Network for Value-Driven Health Plans. For a list of providers, please go to <a href="http://www.hstconnect.com">www.hstconnect.com</a> or call 800.440.7427	This <b>plan</b> does use a <b><u>provider network</u></b> "PHCS Network for VDHP." However, you can receive covered services from any <b><u>provider</u></b> . If you receive a bill from a <b><u>provider</u></b> or <b><u>facility</u></b> for the difference between billed charges and the amount payable by the <b>plan</b> and is more than your <b><u>cost-sharing</u></b> amount under the <b>plan</b> , please contact The Health Plan 888.816.3096
Do you need a <b><u>referral</u></b> to see a <b><u>specialist</u></b> ?	No.	You can see the <b><u>specialist</u></b> you choose without a <b><u>referral</u></b> .

 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)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a>	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> Lab services: \$5 <a href="#">copay</a> , then 20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	\$25 <a href="#">copay</a> , then 20% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> or call 1.800.334.8134	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> /retail \$15 <a href="#">copay</a> /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, <a href="#">deductible</a> does not apply.  Retail Pharmacy- 30-day supply Mail Order- 90-day supply  <a href="#">Precertification</a> is required for certain drugs.
	Preferred brand drugs (Tier 2)	\$40 <a href="#">copay</a> /retail \$50 <a href="#">copay</a> /mail order	
	Non-preferred brand drugs (Tier 3)	\$40 <a href="#">copay</a> /retail \$50 <a href="#">copay</a> /mail order	
	<a href="#">Specialty drugs</a> (Tier 4)	Same as applicable retail copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	<a href="#">Precertification</a> is required
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> , then 20% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived	Emergency room copay is waived if admitted
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$75 <a href="#">copay</a> , then 20% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived	None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>copay</u> , then 20% <u>coinsurance</u>	<u>Precertification</u> is required
	Physician/surgeon fees	20% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician office visit: \$20 <u>copay</u> Outpatient: 20% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	<u>Precertification</u> is required
If you are pregnant	Office visits	\$20 <u>copay</u>	Cost sharing does not apply to certain preventive services. Depending on the type of services, <u>deductible</u> , <u>copayment</u> , or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	<u>Precertification</u> is required. Limited to 120 visits per calendar year
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	<u>Precertification</u> is required for inpatient services. Manipulation therapy is limited to 12 visits per calendar year. Physical, occupational and speech therapies are limited to 20 visits per therapy type, per calendar year
	<a href="#">Habilitation services</a>	20% <u>coinsurance</u>	None
	<a href="#">Skilled nursing care</a>	\$100 <u>copay</u> , then 20% <u>coinsurance</u> <u>Deductible</u> waived	<u>Precertification</u> is required. Limited to 70 visits per calendar year
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	<u>Precertification</u> is required
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	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)
- Hearing Aids
- Long-term care
- Infertility treatment
- 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.
- Routine eye care (Adult)
- 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](http://www.dol.gov/ebsa/healthreform) or the Department of Health and Human Services at 1.877.267.2323 x61565 or [www.cciio.cms.gov](http://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](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 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](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? 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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist coinsurance</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,560</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist coinsurance</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,270</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist coinsurance</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,150</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.