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, Personify Health (aka HealthComp) at 1-800-442-7247. 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 www.cciio.cms.gov, or https://www.healthcare.gov/sbc-glossary or call 1-800-442-7247 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	Network *Per Calendar Year* $750/Individual $1,500/Family	Out-of-Network *Per Calendar Year* $1,500/Individual $3,000/Family	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 meets the overall family deductible.
	Network and Out-of-Network are combined		
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care visits, Teladoc visits, mental health & substance abuse office visits, nutritional counseling visits, prenatal lab & x-ray including medically necessary genetic testing, and prescription drugs 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.

Important Questions	Answers		Why This Matters:
What is the out-of-pocket limit for this plan?	Network Deductible & Coinsurance *Per Calendar Year* $2,500/Individual $5,000/Family Copayment $2,000/Individual $4,000/Family	Out-of-Network *Per Calendar Year* $16,500/Individual $33,000/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.
	Prescription drugs *Per Calendar Year* $2,100/Individual $4,200/Family		
	Maximum out-of-pocket is combined for Network and Out-of-Network and is separate from the prescription drug Out-of-Pocket maximum.		
What is not included in the out-of-pocket limit?	Premiums, balance billing charges (unless balanced billing is prohibited), health care this plan doesn't cover, and cost containment penalties for failure to obtain precertification when required.		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. www.blueshield.com or call 1-800-442-7247 for a list of network providers.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
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.

* For more information about limitations and exceptions, see the plan or policy document at www.healthcomp.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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40/visit Deductible waived	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge Deductible waived	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by 100%.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.liviniti.com	Generic drugs	**Retail** $10/Prescription **90-day Retail/Mail order** $20/Prescription	Not covered	Covers up to a 31-day supply (retail prescription); 32-90 day supply (retail and mail order prescription). There is no charge for retail or mail order generic preventive/maintenance drugs. If a preferred or non-preferred brand-name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the preferred or non-preferred brand drug and the generic equivalent, plus the standard cost share on drug tier placement.
	Preferred brand drugs	**Retail** $40/Prescription **90-day Retail/Mail order** $80/Prescription	Not covered	
	Non-preferred brand drugs	**Retail** $75/Prescription **90-day Retail/Mail order** $150/Prescription	Not covered	
	Specialty drugs	**Retail** $10/$40/$75/Prescription **Mail order** $20/$80/$150/Prescription	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.healthcomp.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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Out-of-Network ambulatory surgery centers are limited to $20,000 maximum benefit. Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by 100%.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Non-emergency care is not covered.
	Emergency medical transportation	Air 20% coinsurance	Air 20% coinsurance	None
		Ground/Water 20% coinsurance	Ground/Water 20% coinsurance	Non-emergency transport is not covered.
	Urgent care	20% coinsurance	50% coinsurance	Includes physician services.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350/admission + 20% coinsurance	$1,050/admission + 50% coinsurance	The per admission copayment is per calendar year. Precertification is required. If you don't get precertification, benefits could be reduced by 100%.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None

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	**Office** $40/visit $20/visit group visit Deductible waived **Other services** 20% coinsurance	50% coinsurance	Precertification may be required for facility services. If you don't get precertification, benefits could be reduced by 100%.
	Inpatient services	$350/admission + 20% coinsurance	$1,050/admission + 50% coinsurance	The per admission copayment is per calendar year. Precertification is required. If you don't get precertification, benefits could be reduced by 100%.
If you are pregnant	Office visits	No charge Deductible waived	50% coinsurance	Pregnancy of a dependent daughter is not covered, unless required by law. 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	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$350/admission + 20% coinsurance	$1,050/admission + 50% coinsurance	Pregnancy of a dependent daughter is not covered, unless required by law. The per admission copayment is per calendar year. Precertification is only required for stay exceeding 48 hours after delivery (or 96 hours after C-section). If you don't get precertification when required, benefits could be reduced by 100%.

* For more information about limitations and exceptions, see the plan or policy document at www.healthcomp.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)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits per disability. Precertification is required. If you don't get precertification, benefits could be reduced by 100%.
	Rehabilitation services	20% coinsurance	50% coinsurance	Includes, Applied Behavioral Analysis (ABA), occupational, physical and speech therapies. Physical therapy is limited to 20 visits per occurrence per calendar year combined with Habilitation services. Limit does not apply to Habilitation for the treatment of autism spectrum disorders.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	Must begin immediately following a hospital stay, limited to the semi-private room rate & 100 days/disability. Precertification is required. If you don't get precertification, benefits could be reduced by 100%.
	Durable medical equipment	20% coinsurance	50% coinsurance	Jobst garments are limited to 2 pair per calendar year. Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by 100%.
	Hospice services	20% coinsurance	50% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by 100%.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Must enroll in separate vision plan.
	Children's glasses	Not covered	Not covered	Must enroll in separate vision plan.
	Children's dental check-up	Not covered	Not covered	Must enroll in separate dental plan.

* For more information about limitations and exceptions, see the plan or policy document at www.healthcomp.com.

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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids – However, exams for the fitting are covered.
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture – Limited to 24 visits or $250/individual or $750/family paid by Plan per Calendar Year combined with Chiropractic care.
- Bariatric surgery
- Chiropractic care – Limited to 24 visits or $250/individual or $750/family paid by Plan per Calendar Year combined with Acupuncture.
- Infertility treatment – Limited to $15,000 lifetime maximum.
- Private-duty nursing
- Routine foot care – Limited to treatments for metabolic or peripheral-vascular disease.

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: Personify Health (aka HealthComp) at 1-800-442-7247 or 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 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: Personify Health (aka HealthComp) at 1-800-442-7247 or 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 1-800-442-7247.

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, see the plan or policy document at www.healthcomp.com.

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** **20%**
- **Hospital (facility) copay+coins** **$350+20%**
- **Other (Tests) 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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,410**

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** **20%**
- **Hospital (facility) copay+coins** **$350+20%**
- **Other (Brand drugs) copays** **$40**

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	$400
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

- **The plan's overall deductible** **$750**
- **Specialist coinsurance** **20%**
- **Hospital (ER) coinsurance** **20%**
- **Other (Physical Therapy) 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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$300
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,120**

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