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* $500/Individual $1,000/Family	Out-of-Network *Per Calendar Year* $1,000/Individual $2,000/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services payable with a copayment, travel & accommodations, and travel vaccines 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 *Per Calendar Year* $3,500/Individual $7,000/Family	Out-of-Network *Per Calendar Year* $4,000/Individual $8,000/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?	Premiums, balance billing charges (unless balanced billing is prohibited), and 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.

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Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.healthcomp.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.

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/visit	50% coinsurance	None
	Specialist visit	$40/visit	50% coinsurance	None
	Preventive care/screening/ immunization	No charge Deductible waived	50% coinsurance Deductible waived	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)	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.

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

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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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	**Retail** $10/Prescription **Mail order** $20/Prescription	Not covered	Retail is limited to a 30-day supply. Mail order is limited to a 90-day supply.
	Preferred brand drugs	**Retail** $30/Prescription **Mail order** $60/Prescription	Not covered	
	Non-preferred brand drugs	**Retail** $45/Prescription **Mail order** $90/Prescription	Not covered	
	Specialty drugs	50% coinsurance up to a maximum of $200	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$500/visit Deductible waived	$500/visit Deductible waived	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$40/visit Deductible waived	50% coinsurance	None

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

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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 a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office** $25/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.
	Inpatient services	20% coinsurance	50% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
If you are pregnant	Office visits	No charge Deductible waived	50% coinsurance	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	20% coinsurance	50% coinsurance	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.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 100 visits per Calendar year. Precertification is required. If you don't get precertification, benefits could be reduced.
	Rehabilitation services	**Physical, Occupational & Speech therapies** 20% coinsurance	**Physical, Occupational & Speech therapies** 50% coinsurance	Limited to 35 visits combined with Occupational Therapy, Physical Therapy, and Speech Therapy.

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

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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	Habilitation services	$25/visit Deductible waived	50% coinsurance	None
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 180 days per Calendar Year. Precertification is required. If you don't get precertification, benefits could be reduced.
	Durable medical equipment	20% coinsurance	50% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Hospice services	20% coinsurance	50% coinsurance	Limited to 180 days per lifetime. Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	50% coinsurance	Limited to 1 exam per Calendar Year.
	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.

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
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care (Limited to 26 visits per Calendar Year) • Hearing aids (Limited to 1 device per ear every 36 months)	• Private-duty nursing	• Routine eye care (Adult) (Limited to 1 exam per Calendar 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: Personify Health (aka HealthComp) at 1-800-442-7247 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. 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.

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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** **$500**
- **Specialist copays** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other (Diagnositc Tests)** **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	$500
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

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

- **The plan's overall deductible** **$500**
- **Specialist copays** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other (Brand drugs) copays** **$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	$500
Copayments	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

- **The plan's overall deductible** **$500**
- **Specialist copays** **$40**
- **Hospital (ER) copays** **$500**
- **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	$500
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

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