



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, contact 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-442-7247 to request a copy.

Important Questions	Answers		Why This Matters:
<p>What is the overall deductible?</p>	<p>Network None</p>	<p>Out-of-Network \$250/Person \$750/Family 3 must meet</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Emergency room care, Urgent care, Urgent care physician visit when billed separately from the facility, Emergency room physician visit, anesthesia, Emergency medical transportation, and chiropractic.</p>		<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>		<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Network \$1,000/Individual \$3,000/Family</p>	<p>Out-of-Network \$1,500/Individual \$4,500/Family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Cost containment penalties, premiums, balance-billing charges, and health care this plan doesn't cover.</p>		<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

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	30% coinsurance	None
	Specialist visit	\$40/visit	30% coinsurance	None
	Preventive care/screening/immunization	No charge	30% coinsurance	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)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.

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.express-scripts.com	Generic drugs	Retail \$10/prescription <hr/> Mail order \$20/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Maintenance drugs requiring three or more refills must be filled in 90-day supplies.
	Preferred brand drugs	Retail \$25/prescription <hr/> Mail order \$50/prescription	Not covered	
	Non-preferred brand drugs	Retail \$50/prescription <hr/> Mail order \$100/prescription	Not covered	
	Specialty drugs	Retail \$10/\$25/\$50/prescription <hr/> Mail order \$20/\$50/\$100/prescription	Not covered	Copay is based on the type of drug
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150/visit	Ambulatory Surgery Center Not covered <hr/> Hospital 30% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	\$250/visit Deductible waived		Copay waived if admitted. Out-of-Network non-emergent care 30% coinsurance .
	Emergency medical transportation	\$100/trip Deductible waived		None
	Urgent care	\$50/visit	30% coinsurance Deductible 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)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500/admit	30% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit \$25/visit <hr/> Other No charge	30% coinsurance	Precertification may be required for facility services. If you don't get precertification, benefits could be reduced.
	Inpatient services	\$500/admit	30% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
If you are pregnant	Office visits	No charge	30% 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). Dependent daughters are not covered, except care that is required as Standard Preventive Care .
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	\$500/admit	30% 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. Dependent daughters are not covered, except care that is required as Standard Preventive Care

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	No charge	30% coinsurance	Coverage is limited to 100 visits per Calendar Year. Precertification is required. If you don't get a precertification, benefits could be reduced.
	Rehabilitation services	Occupational Therapy No charge	30% coinsurance	None
		Speech Therapy \$25/visit		
		Physical Therapy \$25/visit		
	Habilitation services	Occupational Therapy No charge	30% coinsurance	None
		Speech Therapy \$25/visit		
		Physical Therapy \$25/visit		
Skilled nursing care	50% coinsurance		Coverage is limited to 60 days per occurrence. Precertification is required. If you don't get a precertification, benefits could be reduced.	
Durable medical equipment	20% coinsurance	30% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.	
Hospice services	No charge	30% coinsurance	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	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 .

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](#).)

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|-----------------------|--|----------------------------|
| • Bariatric Surgery | • Infertility Treatment | • Private Duty Nursing |
| • Cosmetic Surgery | • Long Term Care | • Routine Eye Care (Adult) |
| • Dental Care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine Foot Care |
| • Hearing Aids | | • Weight Loss Programs |

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

- Acupuncture and Chiropractic Care (\$25/visit. Limited to 20 visits combined 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: McGriff COBRA Services at 888-888-3442 or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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: 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.

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](#) \$0
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$500
- Other (Tests) [copayment](#) \$0

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$560

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$500
- Other (Brand drugs) [copayment](#) \$25

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$40
- Hospital (ER) [copayment](#) \$250
- Other (Physical Therapy) [copayment](#) \$25

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$750

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