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, call 1-844-297-8432. 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.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-new.pdf or call 1-844-297-8432 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$2,000** individual / **$4,000** family Non-Network: **$3,000** individual / **$6,000** 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, the entire family deductible must be met before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Network preventive care is 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?	Dental: **$50** individual/**$250** family (waived for preventive services)	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: **$7,000** individual / **$14,000** family Non-Network: **$9,850** individual / **$19,700** 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, penalties, amounts in excess of reasonable and customary, and charges not covered by this plan.	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, Healthcare Highways. Call 1-866-945-2292 or visit www.healthcarehighways.com	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)	Non-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 copay per visit after deductible TelaDoc General Medicine - $55 copay per visit TelaDoc Sexual Health – Lab services at cost TelaDoc Caregiver - $55 copay per visit	Deductible waived for all Teledoc services	***Until the annual out-of-pocket limit is reached; then no charge for the rest of the plan year.
	Specialist visit	$50 copay per visit after deductible	40% coinsurance after deductible	----------none----------
	Preventive care/screening/ immunization	No charge	40% coinsurance after deductible	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.
		CDC-approved COVID-19 testing, vaccinations and immunizations: No Charge		
If you have a test	Diagnostic test (x-ray, blood work)	With Lab Card Select: 0% coinsurance after deductible Without Lab Card Select: 20% coinsurance after deductible	40% coinsurance after deductible	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from MaxCare Rx at 1-800-259-7765 or www.mymaxcarerx.com	Generic drugs	Retail (30 day supply): $10 copay Retail or Mail order (90 day supply): $30 copay	Same copayment and min/max (if applicable) for in-network but based on the allowed amount	Retail – 30 day to 90 day supply Mail Order – 90 day supply **The medical deductible must be satisfied before the prescription copayments apply**. Any expenses incurred for covered prescription drugs prior to satisfaction of the deductible will be applied to the deductible. Once the Network out-of-pocket amount has been met, copayments for covered prescription drugs will no longer apply for the remaining plan year. Copay amounts are per prescription. Preferred brand drug category includes compound medications, which are limited to a 30 day supply. If a Generic is available and allowed by the Physician, the individual will be required to pay the Brand copay and the difference in cost between the Generic and Brand name if Brand is chosen.
	Preferred brand drugs	Retail (30 day supply): 40% or $125, whichever is less Retail or Mail order (90 day supply): $150 copay	Same as above	
	Non-preferred brand drugs	Retail (30 day supply): 50% or $150, whichever is less Retail or Mail order (90 day supply): $200 copay	Same as above	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Specialty drugs	Generic - Retail (30 day supply): 20% or $100, whichever is less Brand Name - Retail (30 day supply): 20% or $150, whichever is less (No Mail order.)	Same as above	Specialty drugs are limited to a 30 day supply per fill and require prior authorization, call MaxCare Rx at 1-800-259-7765.
		Copay amounts may differ for Specialty Drugs subject to the Smart Rx Assist Program, which is a part of the **Medical** plan, not the pharmacy benefit**		**The Medical plan has implemented the Smart Rx Assist Program in order to utilize financial rebates, discounts and/or assistance programs offered by third-party specialty drug manufacturers. The plan has imposed special utilization requirements for certain specialty drugs. The list of specialty drugs subject to this program can be found here: https://myhealth.healthsmart.com/Login.aspx?ReturnUrl=%2fsecure%2fDefault.aspx For more information about the Smart Rx Assist Program, please call HealthSmart Rx at 1-800-681-6912.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Some procedures require precertification. Call HealthSmart 1-877-202-6379.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	----------none----------
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	Network deductible and out-of-pocket limit will apply to non-Network providers.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Network deductible and out-of-pocket limit will apply to non-Network providers.
	Urgent care	$25 copay per visit after deductible	40% coinsurance after deductible	----------none----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Precertification is required, call HealthSmart at 1-877-202-6379.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Teladoc consultations: Psychiatrist initial visit $220 copay; Psychiatrist recurring visit $100 copay; Psychologist, counselor or therapist visit $90 copay	Deductible waived for all Teledoc services.	***Until the annual out-of-pocket limit is reached; then no charge for the rest of the plan year.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Precertification is required, call HealthSmart at 1-877-202-6379.
If you are pregnant	Office visits	With participation in the Mother & Child program: 0% coinsurance after deductible for routine obstetric exams and delivery charges (does not apply to diagnostic, x-ray and lab services, which are 20% coinsurance after deductible) Without participation in the Mother & Child program: 20% coinsurance after deductible	40% coinsurance after deductible	Not covered for dependent children. This exclusion does not apply to any service or supply required by the Patient Protection and Affordable Care Act (PPACA) to be included as a covered expense under the Preventive benefit. To enroll in the Mother and Child Program, call HealthSmart at 1-877-202-6379 during the 1st trimester, or as soon as pregnancy is confirmed.
	Childbirth/delivery professional services	With Mother & Child program: 0% coinsurance after deductible	40% coinsurance after deductible	Not covered for dependent children.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		Without Mother & Child program: 20% coinsurance after deductible		
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	Precertification is required for maternity stays in excess of 48 hours (or 96 hours for cesarean delivery). Not covered for dependent children.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Precertification is required, call HealthSmart at 1-877-202-6379.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Inpatient rehabilitation requires precertification, call HealthSmart at 1-877-202-6379.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Occupational, Physical and Speech therapy services require precertification, call HealthSmart at 1-877-202-6379.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Precertification is required, call HealthSmart at 1-877-202-6379.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Precertification is required for items over $500, call HealthSmart at 1-877-202-6379.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Precertification is required, call HealthSmart at 1-877-202-6379.
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance after deductible	Routine vision screening for children under the Preventive benefit.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	No charge		The Dental plan deductible is waived for preventive services.

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
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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.)

- Chiropractic care
- Dental care (Adult & Child)
- Hearing aids (Limit once every 3 years.)
- Non-surgical treatment of TMJ
- Private-duty nursing

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-405-606-3741. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. 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 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 Claims Administrator at 1-844-297-8432. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 1-844-297-8432.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-297-8432.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-297-8432.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-297-8432.

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	$2,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	20%
Other 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	$2,000
Copayments	$0
Coinsurance	$1,940
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,000**

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

The plan's overall deductible	$2,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	20%
Other coinsurance	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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$95
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,150**

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

The plan's overall deductible	$2,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$2,000
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

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