**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 855-255-7060. 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 855-255-7060 to request a copy.

| Important Questions | Answers | | Why This Matters: |
|---|---|---|---|
| **What is the overall deductible?** | In-Network<br>$1,500/self only<br>$1,500/individual<br>$3,000/family | Out-of-Network<br>$3,000/self only<br>$3,000/individual<br>$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, 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. |
| | In-network and out-of-network deductibles are combined. | | |
| **Are there services covered before you meet your deductible?** | Yes, preventive services, certain services paid with a copayment, services paid at no charge, and certain out-of-network services. | | 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?** | In-Network<br>$6,000/self only<br>$6,000/individual<br>$12,000/family | Out-of-Network<br>$12,000/self only<br>$12,000/individual<br>$24,000/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 out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| | In-network and out-of-network out-of-pocket limits are combined. | | |
| **What is not included in the out-of-pocket limit?** | Premiums, balance billing charges (unless balance billing is prohibited), health care this plan doesn't cover, prescription drug third-party & manufacturer coupons or rebates, and penalties for failure to obtain pre-certification for services. | | 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. See www.mycarehc.com or call 855-255-7060 for a list of in-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 in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |

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

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **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 |
|---|---|---|---|---|
| | | In-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 | $30 copay/visit, deductible does not apply; 0% coinsurance for other outpatient services | 25% coinsurance | In-network provider copay is per provider and applies to the office visit charge, allergy treatment (injections), allergy serum, and in-office x-ray/lab services. Coinsurance applies for all other covered in-office services. |
| | Specialist visit | $60 copay/visit, deductible does not apply; 0% coinsurance for other outpatient services | 25% coinsurance | |
| | Preventive care/screening/ immunization | No charge | 50% coinsurance, deductible does not apply | None |
| **If you have a test** | Diagnostic test (x-ray, blood work) | **X-ray:** $60 copay<br>**Lab:** $40 copay | 25% coinsurance | In-network x-ray & lab services performed in the office are covered under the office copay. |
| | Imaging (CT/PET scans, MRIs) | $300 copay | 25% coinsurance | Precertification is required or services may be denied. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-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.mycarehc.com | Generic drugs | **Retail** $10/prescription **Mail order** $20/prescription | Not covered | Covers up to a 30-day supply (retail pharmacy); 90-day supply (mail order pharmacy). Deductible does not apply to prescription drugs. Specialty drugs are limited to a 30-day supply and must be purchased from Welldyne Specialty pharmacy. Specialty drugs above $5,000 are typically not covered. Prescription drug third-party & manufacturer coupons or rebates: Your costs for certain specialty drugs could be lower when using the third-party copayment assistance program. To determine if a specialty drug or alternative will be covered, or for more information about the WellAssist program, contact your employer. |
| | Preferred brand drugs | **Retail** $25/prescription **Mail order** $50/prescription | | |
| | Non-preferred brand drugs | **Retail & Mail Order** 50% coinsurance | | |
| | Specialty drugs | **Retail** $200/prescription | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $500 copay | 25% coinsurance | Precertification is required or services may be denied. |
| | Physician/surgeon fees | 0% coinsurance | 25% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $300 copay/visit | | None |
| | Emergency medical transportation | No charge | | None |
| | Urgent care | $40 copay/visit, deductible does not apply | 25% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance | 25% coinsurance | Precertification is required or services may be denied. |
| | Physician/surgeon fees | 0% coinsurance | 25% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copay/office visit, deductible does not apply; 0% coinsurance for other outpatient services | 25% coinsurance | In-network provider copay is per provider and applies to the office visit charge only. |
| | Inpatient services | 0% coinsurance | 25% coinsurance | Precertification is required or services may be denied. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | $30 copay/visit, deductible does not apply | 25% coinsurance | Cost sharing does not apply for in-network preventive care 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 | 0% coinsurance | 25% coinsurance | None |
| | Childbirth/delivery facility services | 0% coinsurance | 25% coinsurance | Precertification is required for an inpatient stay that is in excess of 48 hours (vaginal delivery) or 96 hours (caesarean delivery) or services may be denied. |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 25% coinsurance | Precertification is required or services may be denied. Limited to 60 days/plan year. |
| | Rehabilitation services<br>Habilitation services | **Inpatient rehab & Cardiac rehab:** 0% coinsurance<br>**Occupational, Physical, Pulmonary, & Speech therapies:** $60 copay | 25% coinsurance | Occupational, Physical, & Speech therapies are limited to 30 visits each per plan year.<br>Limits do not apply to habilitation services for autism spectrum disorders. |
| | Skilled nursing care | 0% coinsurance | 25% coinsurance | Limited to 60 days per plan year.<br>Precertification is required or services may be denied. |
| | Durable medical equipment | 0% coinsurance | 25% coinsurance | Precertification is required for DME over $5,000 or services may be denied. |
| | Hospice services | **Inpatient**: 0% coinsurance<br>**In-Home**: No charge | 25% coinsurance | Precertification is required or services may be denied. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | 50% coinsurance, deductible does not apply | Limited to 1 exam per plan year per ACA guidelines. |
| | Children's glasses | Not covered | Not covered | No coverage for children's glasses. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental check-up. |

## 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) / (Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (unless ICU is unavailable)
- 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 (limited to 30 visits/plan year)
- Habilitation Services
- Hearing aid (only covered if due to Accidental Injury; limited to $5,000 every 5 years)
- Routine eye care (Child)

**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. 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: 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 855-255-7060.

*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** **$1,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **0%**
- **Other (Tests) copayment** **$40**

**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 | $1,500 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,060** |

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **0%**
- **Other (Brand drug) 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** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $900 |
| Copayments | $500 |
| Coinsurance | $0 |
| *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** **$1,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **0%**
- **Other (Physical Therapy) copayment** **$60**

**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 | $1,200 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,700** |

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