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 your employer. 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 Individual / $0 Family for In-Network $1,000 Individual / $2,000 Family for Out-of-Network Deductible is embedded.	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.
Are there services covered before you meet your deductible?	Yes. In-Network preventive care and services covered at "No charge".	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?	$1,250 Individual / $2,500 Family for In-Network $3,750 Individual / $7,500 Family for Out-of-Network Out-Of-Pocket Limit is embedded.	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, Pre-Certification penalties, and health care this plan doesn't cover.	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.frontpathcoalition.com 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.

Benefits and cost sharing accumulate on a Calendar Year basis.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies, unless otherwise stated.

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	$25 copay, deductible does not apply	50% coinsurance after deductible	None
	Specialist visit	$45 copay, deductible does not apply	50% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	Not Covered	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)	30% coinsurance after deductible	50% coinsurance after deductible	Labs performed during network office visit are included in office visit copay.
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification is required on imaging. $500 penalty applies if not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.PhoenixPBM.com	Generic drugs	Retail: $0 copay / prescription, deductible does not apply	Not covered	Prior authorization may be required on certain prescription drugs. Benefits may vary if more than a 30-day supply is needed.
	Preferred brand drugs	Retail: $35 copay / prescription, deductible does not apply	Not covered	
	Non-preferred brand drugs	Retail: $75 copay / prescription, deductible does not apply	Not covered	
	Specialty drugs	Retail: $200 copay / prescription, deductible does not apply	Not covered	Specialty drugs with a gross cost of $2,500 per month are not covered by the plan. The Plan may permit for at least

* For more information about limitations and exceptions, see the plan document.

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)	
				one (1) 30-day fill for each of these drugs during the Benefit Year.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification required on surgical procedures. $500 penalty applies if not obtained.
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$300 copay, deductible does not apply	Same as In-Network	$500 penalty for non-urgent services.
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$45 copay, deductible does not apply	Same as In Network	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification required. $500 penalty applies if not obtained.
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: $25 copay, deductible does not apply Outpatient: 30% coinsurance after deductible	50% coinsurance after deductible	None.
	Inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification is required on inpatient services. $500 penalty applies if not obtained.
If you are pregnant	Office visits	No Charge	No Charge	None
	Childbirth/delivery professional services	30% coinsurance after deductible	50% coinsurance after deductible	None
	Childbirth/delivery facility services	30% coinsurance after deductible	50% coinsurance after deductible	Post-Certification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section. $500 penalty applies if not obtained.
If you need help recovering or have	Home health care	30% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification required. $500 penalty applies if not obtained. 60 visits/Calendar Year.

* For more information about limitations and exceptions, see the plan document.

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)	
other special health needs	Rehabilitation services	30% coinsurance after deductible	50% coinsurance after deductible	Physical, speech, occupational cardiac rehabilitation limited to 35 visits per Calendar Year, combined.
	Habilitation services	30% coinsurance after deductible	50% coinsurance after deductible	
	Skilled nursing care	30% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification required. $500 penalty applies if not obtained. 25 days/Calendar Year.
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification applies on DME, Orthotics, and Prosthetics. $500 penalty applies if not obtained.
	Hospice services	30% coinsurance after deductible	50% coinsurance after deductible	Pre-Certification required for inpatient. $500 penalty applies if not obtained. 15 visits/days per lifetime.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Coverage limited to one exam per Calendar Year
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- Weight loss programs
- Routine eye care (Adult)

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

- Chiropractic care (25 visits per Plan Year)

* For more information about limitations and exceptions, see the plan document.

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: the 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 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 your employer or the 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 1-855-699-5433.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-699-5433.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-699-5433.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-699-5433.

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 document.

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 copay	$45
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$0
Copayments	$90
Coinsurance	$1,160
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,310**

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 copay	$45
Hospital (facility) coinsurance	30%
Other coinsurance	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	$0
Copayments	$240
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$460**

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

The plan's overall deductible	$0
Specialist copay	$45
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency Department: Facility *(including medical supplies)*
Diagnostic Services *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$950
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**

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