

 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 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:
What is the overall deductible ?	\$1,350 /Single Plan or \$2,700 /Family Plan	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. Preventive care is covered before you meet your deductible , when rendered by a Network Provider.	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 ?	\$5,000 /Single Plan or \$10,000 /Family Plan (embedded family out-of-pocket)	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, utilization management 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.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	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	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. As defined in the Patient Protection and Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Out-of-Network maximum \$800 per procedure. Precertification may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envisionrx.com	Generic drugs (Tier 1)	Retail: \$10 copay /prescription Mail order: \$20 copay /prescription	Retail: \$10 copay /prescription, plus all charges in excess of allowable charge. Mail Order: Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Retail not available for Specialty drugs (Tier4). Mail Order for Specialty drugs is limited to a 30 day supply.
	Preferred brand drugs (Tier 2)	Retail: \$25 copay /prescription Mail order: \$50 copay /prescription	Retail: \$25 copay /prescription, plus all charges in excess of allowable charge. Mail Order: Not Covered	
	Non-preferred brand drugs (Tier 3)	Retail: \$50 copay /prescription Mail order: \$100 copay /prescription	Retail: \$50 copay /prescription, plus all charges in excess of allowable charge. Mail Order: Not Covered	
	Specialty drugs (Tier 4)	Retail: Not Available Mail Order: 20% coinsurance	Not covered	

 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Precertification may be required. If you don't get precertification, benefits could be reduced. Out-of-network maximum \$350 per admit.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	Copay is waived if admitted. Copay applies to facility charge only. The emergency room physician may be a separate charge.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Out-of-network air transport not related to an emergency is limited to \$50,000 per trip.
	Urgent care	10% coinsurance	10% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Precertification is required for inpatient services; waived for emergency admissions.
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	Prenatal: No Charge Postnatal: 10% coinsurance	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).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	

 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 need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	100 visits/plan year. Precertification is required. If you don't get a precertification, benefits could be reduced.
	Rehabilitation services	Physical, Speech, Occupational Therapy, & Chiropractic, <u>Other Therapies</u> : 10% coinsurance	Physical, Speech, Occupational Therapy, & Chiropractic, <u>Other Therapies</u> : 30% coinsurance	24 visits/plan combined for chiropractic care, physical and occupational therapy. Additional visits allowed for physical and occupational therapies if medically necessary.
	Habilitation services	Physical, Speech, Occupational Therapy, & Chiropractic, <u>Other Therapies</u> : 10% coinsurance	Physical, Speech, Occupational Therapy, & Chiropractic, <u>Other Therapies</u> : 30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	
	Durable medical equipment	10% coinsurance	30% coinsurance	Precertification is required. If you don't get a precertification, benefits could be reduced.
	Hospice services	10% coinsurance	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Must enroll in separate vision plan for vision benefits
	Children's glasses	Not covered	Not covered	Must enroll in separate vision plan for vision benefits
	Children's dental check-up	Not covered	Not covered	Must enroll in separate dental plan for dental benefits

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](#).)

- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- 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.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids

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 (for ERISA Plans): 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: HealthComp Administrators 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.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-442-7247

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-442-7247.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 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](#) \$1,350
- [Specialist copayment](#) \$0
- [Hospital \(facility\) coinsurance](#) 10%
- Other [coinsurance](#) 10%

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$40
Coinsurance	\$1,260
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,710

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

- The [plan's](#) overall [deductible](#) \$1,350
- [Specialist copayment](#) \$0
- [Hospital \(facility\) coinsurance](#) 10%
- Other [coinsurance](#) 10%

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$635
Coinsurance	\$293
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,333

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

- The [plan's](#) overall [deductible](#) \$1,350
- [Specialist copayment](#) \$0
- [Hospital \(facility\) coinsurance](#) 10%
- Other [coinsurance](#) 10%

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments	\$0
Coinsurance	\$193
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,543

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Human Resources Department.