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 1-800-999-0114 . 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 www.healthcare.gov/sbc-glossary or call 1-855-408-8503 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $250 individual/$500 family Non-Network: $500 individual/$1,000 family	Generally, you must pay all 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, physician office visits, prescription drugs, and certain emergency services.	This plan covers some items and services even if you haven't 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 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: $6,600 individual/$13,200 family Non-Network: $12,700 individual/$25,400 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?	Contributions, balance billing charges, penalties for failure to obtain precertification for services 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.mycoresource.com for a list of network providers.	You pay least if you use a provider in the Cofinity Network. You will pay the most if you use a non-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).
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	$10 copay (deductible does not apply)	50% coinsurance	None.
	Specialist visit	$10 copay (deductible does not apply)	50% coinsurance	Chiropractic care limited to 24 visits per plan year.
	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 your plan.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com	Generic drugs	$10 copay (deductible does not apply) for retail $20 copay (deductible does not apply) for mail order	20% coinsurance after $10 copay (deductible does not apply) for retail Not applicable for mail order	Covers up to a 90 day supply (retail); 31-90 day supply (mail order); 30 day supply Pharmacy (specialty drugs). Copay does not apply to preventive drugs as required by the Affordable Care Act. Generics with Dispense as Written (DAW) override – The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.
	Preferred brand drugs	$30 copay (deductible does not apply) for retail $60 copay (deductible does not apply) for mail order	20% coinsurance after $30 copay (deductible does not apply) for retail Not applicable for mail order	
	Non-preferred brand drugs	$60 copay (deductible does not apply) for retail $120 copay (deductible does not apply) for mail order	20% coinsurance after $60 copay (deductible does not apply) for retail Not applicable for mail order	
	Specialty drugs	20% coinsurance (deductible does not apply) up to a $300 maximum	Not applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	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 need immediate medical attention	Emergency room care	$75 copay (deductible does not apply)	$75 copay (deductible does not apply)	Copay waived if admitted. Use of the emergency room for non-emergency care is not covered.
	Emergency medical transportation	0% coinsurance	0% coinsurance	None.
	Urgent care	$40 copay (deductible does not apply)	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Precertification is required. If precertification is not obtained, benefits will be reduced by $400.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay (deductible does not apply)	50% coinsurance	None.
	Inpatient services	0% coinsurance	50% coinsurance	Precertification is required. If precertification is not obtained, benefits will be reduced by $400.
If you are pregnant	Initial office visit	0% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of service, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (like an ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home Health Care	0% coinsurance	0% coinsurance	Precertification is required. If precertification is not obtained, benefits will be reduced by $400.
	Rehabilitation services	0% coinsurance	50% coinsurance	Physical/occupational/speech therapy limited to 60 visits per plan year.
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	0% coinsurance	0% coinsurance	Limited to 120 days per plan year. Precertification is required. If precertification is not obtained, benefits will be reduced by $400.
	Durable medical equipment	0% coinsurance	0% coinsurance	None.
	Hospice services	0% coinsurance (deductible does not apply)	0% coinsurance (deductible does not apply)	Precertification is required. If precertification is not obtained, benefits will be reduced by $400.

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 your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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 (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult & child)

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment limited to diagnosis, treatment and surgery of underlying condition. Assisted Reproduction services are excluded
- Private duty nursing
- Routine foot care, limited to those persons with a metabolic, neurological or peripheral vascular disease
- Weight loss programs

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 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 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 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.

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 Tier 1 pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist copayments	$10
Hospital (facility) coinsurance	0%
Other coinsurance	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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$370**

Managing Joe's type 2 Diabetes
(a year of routine in Tier 1 care of a well-controlled condition)

The plan's overall deductible	$250
Specialist copayments	$10
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,105**

Mia's Simple Fracture
(Tier 1 emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist copayments	$10
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,645**

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