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, [insert contact information]. 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 **www.benefits.hshs.org** or by calling **1-800-345-9474** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Facility/Network PCP: $0 Network Specialist $900 Individual/$1,800 Family The deductible does not apply to preventive care, physician office visit charges, Network Facility charges, Network PCP charges or prescription drugs	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes	Wellness and preventive care is covered at 100%, not subject to the deductible.
Are there other deductibles for specific services?	Yes. **$150** per person for prescription drug expenses.	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 Facility/Network PCP/Network Specialist $3,000 Individual /$6,000 Family Limit Separate Prescription Drug Out-of-Pocket Limit $1,300 per person/$2,600 Family Limit	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for service, and health care this plan does not 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	
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.

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	Your Costs if You Use a				Limitations & Exceptions
		Network Facility	Network PCP	Network Specialist	Out of Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Applicable	5% Coinsurance	Not Applicable	Not Covered	---none---
	Specialist visit	Not Applicable	Not Applicable	15% Coinsurance	Not Covered	---none--
	Other practitioner office visit	Not Applicable	Not Covered	15% Coinsurance	Not Covered	Coverage is limited to 10 visits per calendar year for Spinal Manipulations.
	Preventive care/screening/ immunization	No Charge	No Charge	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	15% Coinsurance	15% Coinsurance	15% Coinsurance	Not Covered	Network Specialist deductible does not apply
	Imaging (CT/PET scans, MRIs)	15% Coinsurance	15% Coinsurance	15% Coinsurance	Not Covered	Network Specialist deductible does not apply.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Pharmacy	Your Cost If You Use a Non-Network Pharmacy	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.navitus.com	Generic drugs	20% coinsurance	Not covered	A separate prescription drug out-of-pocket limit of $1,300 per person/ $2,600 Family Limit applies. Retail - 30 day supply Mail - 90 day supply If you choose to receive a brand name medication when a direct generic equivalent is available, you must pay the difference in price between the brand drug and its generic equivalent in addition to the applicable copay and coinsurance. Mail order required for coverage of maintenance medications after the second fill at a retail pharmacy. After the initial fill, specialty medications must be filled through Lumicera to be covered. Prior authorization may be required.
	Preferred brand drugs	30% coinsurance	Not covered	
	Non-preferred brand drugs	Retail - $15 copay then 30% coinsurance Mail Order - $45 copay then 30% coinsurance	Not covered	
	Specialty drugs	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	Your Costs if You Use a				Limitations & Exceptions
		Network Facility	Network PCP	Network Specialist	Out of Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% Coinsurance	Not Applicable	Not Applicable	Not Covered	---none---
	Physician/ surgeon fees	Not Applicable	5% Coinsurance	15% Coinsurance	Not Covered	---none---
If you need immediate medical attention	Emergency room services	$100 copay then 15% Coinsurance	Not Applicable	15% Coinsurance	$100 copay then 15% Coinsurance	Non-emergency care for Network Facility - $300 copay then 30% coinsurance, Professional - 30%, Out of Network non-emergency use of the emergency room is not covered.
	Emergency medical transportation	15% Coinsurance	5% Coinsurance	15% Coinsurance	15% Coinsurance	Deductible does not apply.
	Urgent care	15% Coinsurance	Not Applicable	15% Coinsurance	Not Covered	Assumes services provided by an urgent care facility. If you are travelling outside of your service area, you pay 10% coinsurance for out-of-network urgent care services.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% Coinsurance	Not Applicable	Not Applicable	Not Applicable	Precertification is required.
	Physician/ surgeon fee	Not Applicable	5% Coinsurance	15% Coinsurance	Not Covered	---none---

Common Medical Event	Services You May Need	Your Costs if You Use a				Limitations & Exceptions
		Network Facility	Network PCP	Network Specialist	Out of Network	
If you have mental health, behavioral health, or substance abuse needs	Mental/ Behavioral health outpatient services	15% Coinsurance	5% Coinsurance	15% Coinsurance	Not Covered	Network Specialist deductible does not apply.
	Mental/ Behavioral health inpatient services	15% Coinsurance	5% Coinsurance	15% Coinsurance	Not Covered	Network Specialist deductible does not apply.
	Substance abuse disorder outpatient services	15% Coinsurance	5% Coinsurance	15% Coinsurance	Not Covered	Network Specialist deductible does not apply.
	Substance abuse disorder inpatient services	15% Coinsurance	5% Coinsurance	15% Coinsurance	Not Covered	Network Specialist deductible does not apply.
If you are pregnant	Prenatal and postnatal care	Not Applicable	5% Coinsurance	15% Coinsurance	Not Covered	---none---
	Delivery and all inpatient services	15% Coinsurance	5% Coinsurance	15% Coinsurance	Not Covered	Notification is required.

Common Medical Event	Services You May Need	Your Costs if You Use a				Limitations & Exceptions
		Network Facility	Network PCP	Network Specialist	Out of Network	
If you need help recovering or have other special health needs	Home health care	15% Coinsurance	5% Coinsurance	15% Coinsurance	Not Covered	120 visits per benefit period. Deductible does not apply.
	Rehabilitation services	15% Coinsurance	5% Coinsurance	15% Coinsurance	Not Covered	Deductible does not apply
	Habilitation services	15% Coinsurance	5% Coinsurance	15% Coinsurance	Not Covered	Deductible does not apply
	Skilled nursing care	15% Coinsurance	5% Coinsurance	15% Coinsurance	Not Covered	90 days per admission, renewable after 180 days between discharge and re-admission.
	Durable medical equipment	15% Coinsurance	5% Coinsurance	15% Coinsurance	Not Covered	Deductible does not apply.
	Hospice service	15% Coinsurance	5% Coinsurance	15% Coinsurance	Not Covered	Deductible does not apply.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered	Not Covered	---none---
	Glasses	Not Covered	Not Covered	Not Covered	Not Covered	---none---
	Dental check-up	Not Covered	Not Covered	Not Covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Dental Care (routine adult)
- Hearing Aids
- Infertility treatments
- Long-term care
- Routine eye care (Adult)
- Routine foot care (with the exception of those with diabetes)
- Weight loss program

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery (HSHS Facility only)
- Chiropractic care
- Dental care (specified services only)
- Coverage when traveling/living outside the USA is for urgent / emergency care only
- Private-duty nursing (excluding inpatient services)

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-327-8497.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-327-8497.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-327-8497.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-327-8497.

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	$900
Specialist Coinsurance	10%
Hospital Facility Coinsurance	10%
Other Coinsurance	15%

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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$920
Copayments	$0
Coinsurance	$890
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$1,960**

Example assumes all care is received from Network Facilities and Network Specialists.

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

The plan's overall deductible	$900
Specialist Coinsurance	10%
Hospital Facility Coinsurance	10%
Other Coinsurance	15%

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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$1,130**

Example assumes all care is received from Network Facilities and Network Specialists.

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

The plan's overall deductible	$900
Specialist Coinsurance	10%
Hospital Facility Coinsurance	10%
Other Coinsurance	15%

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	**$1,970**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$100
Coinsurance	$210
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$710**

Example assumes all care is received from Network Facilities and Network Specialists.

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