



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 844-839-6745. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 844-839-6745 to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	<a href="#">Network providers</a> : \$2,000/individual, \$4,000/individual under family or \$4,000/family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. The <a href="#">deductible</a> is <b>Non-Embedded</b> . If you have other family members on the <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay. <b>Deductible year runs 01/01 – 12/31</b>
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This plan covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive care</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive</a> services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other deductibles for specific services?</a>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<a href="#">What is the out-of-pocket limit for this plan?</a>	<a href="#">Network providers</a> : \$3,000/individual, \$6,000/individual under family or \$6,000/family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. The <a href="#">out-of-pocket limit</a> is <b>Non-Embedded</b> . If you have other family members on the <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
<a href="#">What is not included in the out-of-pocket limit?</a>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a network provider?</a>	Yes. See <a href="http://www.AvenueConsultantsBenefits.com">www.AvenueConsultantsBenefits.com</a> or call 844-839-6745 for a list of <a href="#">network providers</a> .	This plan uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ).
<a href="#">Do you need a referral to see a specialist?</a>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 Network Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	None.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	None.
	<u>Preventive care/screening/</u> immunization	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	None.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	May require <u>preauthorization</u>
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.AvenueConsultantsBenefits.com">www.AvenueConsultantsBenefits.com</a>	Generic drugs	30-day supply Retail: 20% <u>coinsurance/Prescription</u> 90-day supply Mail Order: 20% <u>coinsurance/Prescription</u>	<u>Cost sharing</u> does not apply for <u>preventive Prescriptions</u> . <u>Deductible</u> does not apply to <u>copayment</u> for Generic and Preferred Brand Expanded Preventive Prescriptions. & Mail Order available up to a 90-day supply.
	Expanded Preventive Generic drugs	30-day supply Retail: \$10 <u>copayment/Prescription</u> 90-day supply Mail Order: \$30 <u>copayment/Prescription</u>	
	Preferred brand drugs	30-day supply Retail: 20% <u>coinsurance/Prescription</u> 90-day supply Mail Order: 20% <u>coinsurance/Prescription</u>	
	Expanded Preventive Preferred Brand drugs	30-day supply Retail: \$25 <u>copayment/Prescription</u> 90-day supply Mail Order: \$90 <u>copayment/Prescription</u>	
	Non-preferred Brand drugs	30-day supply Retail: 40% <u>coinsurance/Prescription</u> 90-day supply Mail Order: 40% <u>coinsurance/Prescription</u>	
	<u>Specialty drugs</u>	30-day supply Retail: 40% <u>coinsurance/Prescription</u>	
			Retail & Mail Order available up to a 30-day

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information	
			supply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	May require <a href="#">preauthorization</a> .	
	Physician/surgeon fees	20% <a href="#">coinsurance</a>		
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	True emergency covered at in-network level.	
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	True emergency covered at in-network level.	
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	None.	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.	
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	None.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	None.	
	Inpatient services	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.	
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive</a> services. Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC.	
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>		
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>		
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required. 60 days per year maximum	
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	Occupational Therapy: 40 visit limit/year. Speech Therapy: 40 visit limit/year. Physical Therapy: 40 visit limit/year.	
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>		
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required. 31 days per year maximum	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	None.	
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.	
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limit of 1 routine exam per 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.)

- Cosmetic surgery
- Weight loss programs
- Dental Care (Adult)
- Bariatric Surgery
- Acupuncture
- Long-term care
- Non-emergency care when traveling outside the U.S.

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

- Infertility Treatment (correction of physiological abnormalities)
- Routine Eye Care (one exam/year)
- Routine Foot Care
- Emergency care when traveling outside the U.S.
- Chiropractic Care
- Private Duty Nursing (inpatient only)

**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](http://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](http://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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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 844-839-6745]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-839-6745]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-839-6745]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 844-839-6745]

————— *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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist Copayment</a>	20%
■ Hospital (facility) <a href="#">Coinsurance</a>	20%
■ Other <a href="#">Coinsurance</a>	20%

This EXAMPLE event includes services like:  
[Specialist](#) office visits (prenatal care)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic test](#) (ultrasounds and blood work)  
[Specialist](#) visit (anesthesia)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,160</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist Copayment</a>	20%
■ Hospital (facility) <a href="#">Coinsurance</a>	20%
■ Other <a href="#">Coinsurance</a>	20%

This EXAMPLE event includes services like:  
 Primary care physician office visits (including disease education)  
[Diagnostic test](#) (blood work)  
 Prescription drugs  
[Durable medical equipment](#) (glucose meter)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,220</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist Copayment</a>	20%
■ Hospital (facility) <a href="#">Coinsurance</a>	20%
■ Other <a href="#">Coinsurance</a>	20%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,000</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.