**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 1-800-638-2603. 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 1-800-638-2603 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network providers: **$400**/individual, **$1,200**/family; Out-of-network providers: **$900**/individual, **$2,700**/family | 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, prescription drugs, in-network primary care visits, in-network urgent care, dental and vision are covered before you meet your deductible. | 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 www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. **$10**/individual for vision and **$75**/individual, **$225**/family for dental. There are no other specific deductibles. | 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 providers: **$2,900**/individual, **$12,700**/family; in-network deductible counts toward in-network out-of-pocket limit.<br>Out-of-network providers: **$5,000**/individual; out-of-network deductible does not count toward out-of-network out-of-pocket limit. | 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, if applicable. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, the out-of-network deductible, penalties for failure to obtain preauthorization 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.nasifund.org or call 1-800-810-BLUE 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 |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| | | 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; deductible does not apply. No charge for virtual office visits through MDLIVE. | 40% coinsurance | None |
| | Specialist visit | 20% coinsurance | 40% coinsurance | None |
| | Preventive care/screening/ immunization | No charge. Deductible does not apply. | 40% coinsurance | Subject to age and frequency guidelines. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.optumrx.com | Generic drugs | No charge | No charge | Deductible does not apply. Retail limited to up to a 30-day supply; mail order limited to up to a 90-day supply. If you request a brand name drug when a generic equivalent is available, you will be charged the difference in the cost between the brand name drug and the generic substitute. Maintenance drugs purchased at retail are subject to reimbursement limitation. Drugs obtained from an out-of-network pharmacy are limited to the in-network |
| | Preferred brand drugs | 15% coinsurance | 15% coinsurance | |
| | Non-preferred brand drugs | 30% coinsurance | 30% coinsurance | |

| 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) | |
| | Specialty drugs | 20% coinsurance for preferred brand specialty drugs; 30% coinsurance for non-preferred brand specialty drugs | Not covered | allowance. For specialty drugs, you must use the Optum Rx specialty pharmacy. GLP-1 medications prescribed for weight loss or sleep apnea are not covered. No charge for ACA required generic preventive drugs (or brand name preventive drugs if a generic is not medically appropriate). Not all prescription drugs are covered. Free diabetic test strips and glucometer through Optum's Diabetes Management Program. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance except as required under federal law. | None |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance except as required under federal law. | None |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 40% coinsurance except as required under federal law. | Professional/physician charges may be billed separately. Includes medical screening and further medical examination and treatment required to stabilize the patient. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance for air ambulance; 40% coinsurance for all other emergency medical transportation | Limited to emergency transportation to or from the nearest hospital equipped to provide the required medical care. |
| | Urgent care | 10% coinsurance; deductible does not apply. | 40% coinsurance except as required under federal law. | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance except as required under federal law. | Preauthorization is required. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance except as required under federal law. | None |

| 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 mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance. No charge for virtual office visits through MDLIVE. | 40% coinsurance except as required under federal law. | None |
| | Inpatient services | 20% coinsurance | 40% coinsurance except as required under federal law. | Preauthorization is required. |
| **If you are pregnant** | Office visits | No charge for routine prenatal office visits. 20% coinsurance for all other office visits. | 40% coinsurance except as required under federal law. | Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or a deductible may apply. Maternity care may include tests and services described somewhere else in the SBC (e.g., ultrasound). |

| 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** | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | Limited to hemodialysis, IV therapy and physician visits. |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| | Home health care | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Rehabilitation services | 20% coinsurance | 40% coinsurance | None |
| | Habilitation services | Not covered | Not covered | You must pay 100% of these expenses, even in-network. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | None |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | None |
| | Hospice services | 20% coinsurance | 40% coinsurance | None. |
| **If your child needs dental or eye care** | Children's eye exam | No charge after $10 vision deductible. Overall deductible does not apply. | Not covered | Limited to one exam in a 12-month period unless more than one exam is medically necessary. Vision benefits are administered separately from the medical plan by VSP. |
| **If your child needs dental or eye care** | Children's glasses | No charge after $10 vision deductible. Overall deductible does not apply. | Not covered | Limited to one pair in a 12-month period unless more than one pair is medically necessary. Vision benefits are administered separately from the medical plan by VSP. |
| | Children's dental check-up | 10% coinsurance after $75 dental deductible. Overall deductible does not apply. | 10% coinsurance after $75 dental deductible. Overall deductible does not apply. | Dental benefits are administered separately from the medical plan by Delta Dental. |
| | | | | |

## 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
- Cosmetic surgery (except to repair or alleviate damage resulting from or caused by injury, congenital defect or disfigurement related to disease)
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs (except as required by the Affordable Care Act)

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

- Bariatric surgery
- Chiropractic care (limited to 26 visits per year)
- Dental care (Adult) (limited to $4,000 per year)
- Hearing aids (limited to $1,200 per individual in a 3-year period for members and spouses; includes coverage for dependent children who meet specific criteria)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

**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 on how 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 plan at 1-800-638-2603. You may also 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**

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 1-800-638-2603.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-638-2603.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-638-2603.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-638-2603.

*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** | **$400** |
| **Specialist coinsurance** | **20%** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**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 | $400 |
| Copayments | $0 |
| Coinsurance | $2,150 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,610** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$400** |
| **Specialist coinsurance** | **20%** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**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 | $400 |
| Copayments | $0 |
| Coinsurance | $600 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,000** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$400** |
| **Specialist coinsurance** | **20%** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **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** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $400 |
| Copayments | $0 |
| Coinsurance | $480 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$880** |

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