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, https://portal.employeeplansllc.com. 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 1-800-964-7444 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500/single or $1,000/family** Wellness credits are available and may reduce deductible.	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, physician visits, urgent care, preventive care, supplemental accident and services provided by labcorp.**	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 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?	**$2,000 single/$5,000 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?	**Penalties for failure to obtain preauthorization for services, premiums, balance-billing charges, prescription drug cost and healthcare 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. See www.medpartnersonline.com or call 1-800-258-0974 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 a non-preferred 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 a non-preferred 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
		Preferred Provider (You will pay the least)	Non-Preferred 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	$25/visit	Not covered	Office visit co-pay applies to the physician charges only, all other charges including labs & x-ray, are subject to the deductible & co-insurance. 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.
	Specialist visit	$25/visit	Not covered	
	Preventive care/screening/ immunization	No charge, deductible does not apply	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	See the Plan's Schedule of Benefits for NON-PAR PAY AS PAR provisions. No charge at Labcorp Facility
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	---------- None ----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	20% coinsurance	Not covered	Limited to: 30 day supply retail prescription 90 day supply mail order prescription Maximum out-of-pocket at a preferred provider - Single $1,500/ Family $7,700.
	Preferred brand drugs	30% coinsurance	Not covered	
	Non-preferred brand drugs	50% coinsurance		
	Specialty drugs	20% coinsurance-generic 30% coinsurance-brand 50% coinsurance-non-preferred brand	Not covered	Limited to: 90 day supply Maximum out-of-pocket at a preferred provider – Single $1,500/ Family $7,700
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	---------- None ----------
	Physician/surgeon fees	20% coinsurance	Not covered	See the Plan's Schedule of Benefits for NON-PAR PAY AS PAR provisions.
If you need immediate medical attention	Emergency room care	$100/visit then 20% coinsurance		Copay waived if admitted to the hospital.
	Emergency medical transportation	20% coinsurance	Not covered	Must be medically necessary.

* For more information about limitations and exceptions, see the plan or policy document at https://portal.employeeplansllc.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	Urgent care	$40/visit	Not covered	Office visit co-pay applies to the physician charges only, all other charges including labs & x-ray, are subject to the deductible & co-insurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Penalties for failure to obtain preauthorization for services subject to a $250 per admission penalty.
	Physician/surgeon fees	20% coinsurance	Not covered	See the Plan's Schedule of Benefits for NON-PAR PAY AS PAR provisions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 co-pay/visit All others 20% coinsurance	Not covered	Office visit co-pay applies to the physician charges only, all other charges including labs & x-ray, are subject to the deductible & co-insurance.
	Inpatient services	20% coinsurance	Not covered	Penalties for failure to obtain preauthorization for services subject to a $250 per admission penalty.
If you are pregnant	Office visits	20% coinsurance	Not covered	Charges for Office visits are considered under the global delivery fee. Cost sharing does not apply for preventive services. 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. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Preauthorization is required for hospital stays greater than 2 days for a normal delivery and 4 days for a C-section.
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Limited to 130 visits per calendar year, four (4) hours of service shall be considered one (1) visit.
	Rehabilitation services	20% coinsurance	Not covered	Speech therapy must be due to loss or impairment due to illness or injury, other than a functional disorder.
	Habilitation services	20% coinsurance	Not covered	Limitations may apply based on the type of service rendered. Refer to your plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	Not covered	Limited to 130 visits per calendar year, four (4) hours of service shall be considered one (1) visit.
	Durable medical equipment	20% coinsurance	Not covered	---------- None ----------
	Hospice services	20% coinsurance	Not covered	---------- None ----------
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Covered under preventive per preventive health care requirements.
	Children's glasses	Not Covered	Not Covered	---------- None ----------
	Children's dental check-up	Not Covered	Not Covered	Covered under preventive per preventive health care requirements.

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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Experimental/ Investigational Services
- Hearing Aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal Comfort Items
- Routine Eye care (Adult)
- Routine Foot Care
- Sex Transformation or sexual dysfunctions

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

- Chiropractic Care – 26 visits per calendar year
- Private Duty Nursing
- Weight Loss Programs-only when medical treatment of morbid obesity is due to a direct and immediate threat to life.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Indiana Department of Insurance, Consumer Service Department, 311 West Washington Street, Suite 300, Indianapolis IN 46204-2787, or go to http://www.in.gov/idoi/2547.htm#2.

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.

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** **$500**
- **Specialist *copayment*** **$25**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *Pharmacy 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	$500
Copayments	$0
Coinsurance	$1500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2000**

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

- **The plan's overall deductible** **$500**
- **Specialist *copayment*** **$25**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *Pharmacy 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	$500
Copayments	$200
Coinsurance	$900
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1600**

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

- **The plan's overall deductible** **$500**
- **Specialist *copayment*** **$25**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *Emergency Room copayment*** **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	$500
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1000**

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