

 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, please call 1-877-405-2926. 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 by calling 1-877-405-2926 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>Tier 1: \$0 / \$0; Tier 2 In-Network/Participating <a href="#">Providers</a>/ Participating \$3,500/person; \$7,000/family; Tier 3 Out-of-Network/Non-participating <a href="#">Providers</a>: Not Covered</p>	<p>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. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive Care Services</a>, and some services that charge a <a href="#">copayment</a>, such as primary care, specialty care and prescription drugs are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> 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 <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>Tier 1 &amp; 2 In-Network/Participating <a href="#">Providers</a>: \$7,000/person; \$14,000/family                      Tier 3 Out-of-Network/Non-participating <a href="#">Providers</a>: Not covered</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. Out-of-network costs do not accumulate towards the out-of-pocket maximum.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p>Penalties for non-compliance with <a href="#">plan</a> provisions; <a href="#">premiums</a>; <a href="#">balance-billing</a> charges and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they do not count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. <a href="https://medivi.6degreeshealth.com">https://medivi.6degreeshealth.com</a> or call 877-405-2926 for a list of <a href="#">network providers</a>.</p>	<p>You pay the least if you use Tier 1 providers to whom you are referred by your Care Coordination Team. Tier 1 benefits are not guaranteed. You pay more if you use a Tier 2 In-Network/Participating <a href="#">provider</a>. You will pay the most if you use a non-participating/ <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>).</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without permission from this plan.</p>



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies. If the deductible does not apply, neither does coinsurance.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No charge (through select partner)	\$25 <a href="#">Copay</a> /Office Visit	Not Covered	Other services performed in a physician's office setting (including but not limited to minor surgery or procedures) are subject to deductible and coinsurance.
	<a href="#">Specialist</a> visit	Not applicable. See Tier 2 benefit.	\$50 <a href="#">Copay</a> /Office Visit	Not Covered	Other services performed in a physician's office setting (including but not limited to minor surgery or procedures) are subject to deductible and coinsurance.  <b>Outpatient Hospital: 20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a></b>
	Chiropractic Services	Not applicable. See Tier 2 benefit.	\$45 <a href="#">Copay</a> /Office Visit	Not Covered	Limited to 12 visits per calendar year.
	<a href="#">Preventive care/screening/immunization</a>	Not applicable. See Tier 2 benefit.	Covered in Full	Not Covered	Preventive Services are as outlined by the Patient Protection & Affordable Care Act. 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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (blood work)	Not applicable. See Tier 2 benefit.	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a>	Not Covered	None.
	Imaging (X-Ray, CT/PET scans, MRIs)	No charge	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a>	Not Covered	Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					<p>elsewhere may not be covered.</p> <p>If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum.</p> <p>Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit.</p> <p>Tier 1 benefits are not guaranteed.</p>
<p><b>If you need drugs to treat your illness or condition</b>                      More information about <a href="http://www.writewise.com">prescription drug coverage</a> is available at <a href="http://www.writewise.com">www.writewise.com</a>.</p>	Generic drugs	Not applicable. See Tier 2 benefit.	\$0 <a href="#">Copoly</a> /Prescription (30-day) \$0 <a href="#">Copoly</a> /Prescription (90-day)	Not Covered	<p>Covers up to a 30-day supply (retail); 90-day supply (retail/mail order).</p> <p>Formulary: <a href="http://www.writewise.com/files/Premier-Plus-Plan.pdf">www.writewise.com/files/Premier-Plus-Plan.pdf</a></p> <p>Visit <a href="http://writewiserx.americaspharmacy.com/">writewiserx.americaspharmacy.com/</a> to access Discount Card.</p>
	Preferred brand drugs	Not applicable. See Tier 2 benefit.	\$0 <a href="#">Copoly</a> /Prescription (30-day) \$0 <a href="#">Copoly</a> /Prescription (90-day)	Not Covered	
	Non-preferred brand drugs	Not applicable. See Tier 2 benefit.	Not Covered; Discount Card Available.	Not Covered	
	<a href="#">Specialty drugs</a>	Not applicable. See Tier 2 benefit.	Not Covered; Discount Card Available.	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a> , plus amounts that exceed the Maximum Allowable Charge		<p>Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered.</p> <p>If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum.</p> <p>Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit.</p> <p>Tier 1 benefits are not guaranteed.</p> <p>For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by reimbursing hospitals and facilities based</p>
	Physician/surgeon fees	No charge	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a> ,	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.
<b>If you need immediate medical attention</b>	Emergency room care	Not applicable. See Tier 2 benefit.	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a>		<p>If admitted, preauthorization must be requested within 48 hours of the service date or as soon as reasonably possible. If requested timely, no preauthorization reduction will apply. If not requested within 48 hours, the Plan may apply the 25% post-service reduction.</p> <p>For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by reimbursing hospitals and facilities based on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.</p>
	Emergency medical transportation	Not applicable. See Tier 2 benefit.	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a>		<p>ALS and Air Ambulance are only covered when medically necessary and the only option.</p> <p>For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by</p>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					reimbursing hospitals and facilities based on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.
	Urgent care	No charge (through select partner)	\$75 <a href="#">Copay</a> /Office Visit (standalone clinic)	Not Covered	<b>Outpatient Hospital:</b> 20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a>
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not applicable. See Tier 2 benefit.	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a> , plus amounts that exceed the Maximum Allowable Charge		<p>Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered.</p> <p>If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum.</p> <p>Post-service authorization requests received more than 30 days after the date</p>
	Physician/surgeon fees	Not applicable. See Tier 2 benefit.	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					<p>of service will not be approved, and the service will remain a non-covered benefit.</p> <p>Tier 1 benefits are not guaranteed.</p> <p>For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by reimbursing hospitals and facilities based on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.</p>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge (through select partner)	\$25 <a href="#">Copay</a> / Office Visit (Provider's Office)  20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a> (Outpatient hospital)	Not Covered	<p><b>Inpatient Services:</b>                      Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered.</p> <p>If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum.</p> <p>Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit.</p> <p>Tier 1 benefits are not guaranteed.</p> <p>For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by</p>
	Inpatient services	No charge	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a> , plus amounts that exceed the Maximum Allowable Charge		

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					reimbursing hospitals and facilities based on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.
If you are pregnant	Office visits	Not applicable. See Tier 2 benefit.	Initial Visit: \$50 <a href="#">Copay</a> / Office Visit Subsequent Visits: No Charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).  Tier 1 benefits are not guaranteed.
	Childbirth/delivery professional services	No charge	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a>	Not Covered	
	Childbirth/delivery facility services	No charge	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a> , plus amounts that exceed the Maximum Allowable Charge		Prior authorization may be required for stays exceeding 48 hours (vaginal deliveries) or 96 hours (caesarian deliveries).  Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					<p>If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum.</p> <p>Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit.</p> <p>Tier 1 benefits are not guaranteed.</p> <p>For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by reimbursing hospitals and facilities based on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.</p>
If you need help recovering or have other special health	<a href="#">Home health care</a>	No charge	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a>	Not Covered	<p>Limited to 180 visits per calendar year.</p> <p>Preauthorization is a condition of benefit eligibility under this Plan. Except as</p>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
needs					<p>provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered.</p> <p>If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum.</p> <p>Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit.</p> <p>Tier 1 benefits are not guaranteed.</p>
	<a href="#">Rehabilitation services</a>				Rehabilitation & Habilitation: Combined limit of 30 days per calendar year.
	<a href="#">Habilitation services</a>	No charge	\$50 <a href="#">Copay</a>	Not Covered	Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					<p>the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered.</p> <p>If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum.</p> <p>Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit.</p> <p>Tier 1 benefits are not guaranteed.</p> <p>Limit of 30 days per calendar year.</p>
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a> , plus amounts that exceed the Maximum Allowable Charge		<p>Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered.</p>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					<p>If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum.</p> <p>Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit.</p> <p>Tier 1 benefits are not guaranteed.</p> <p>For hospitals and facilities, the Maximum Allowable Charge paid by your plan is based on a reference-based price. Reference-based pricing works by reimbursing hospitals and facilities based on objective criteria. Most commonly, the criteria will be Medicare-published costs and pricing data, plus an additional percentage. This allows for a reasonable reimbursement that is fair to the hospital and facility, and a savings to the plan.</p>
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a>	Not Covered	Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without

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		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					<p>required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered.</p> <p>If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum.</p> <p>Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit.</p> <p>Tier 1 benefits are not guaranteed.</p>
	<a href="#">Hospice services</a>	No charge	20% <a href="#">Coinsurance</a> after Annual <a href="#">Deductible</a>	Not Covered	<p>Benefits limited to 30 days per calendar year.</p> <p>Preauthorization is a condition of benefit eligibility under this Plan. Except as provided below, services rendered without required Preauthorization are not covered benefits, and no payment will be made by the Plan. The Plan may require the use of a</p>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network/Participating Provider)	Tier 3 (Out-of-Network/Non-Participating Provider)	
					<p>Designated Provider or Designated Site of Care. In certain instances, services obtained elsewhere may not be covered.</p> <p>If Preauthorization is not obtained before services are rendered, the ordering or rendering provider may request a post-service authorization within 30 days of the date of service. If the post-service authorization is approved, the Plan's allowable amount for the covered service(s) will be reduced by 25%. The member is responsible for this reduction amount, which will not apply toward the deductible or out-of-pocket maximum.</p> <p>Post-service authorization requests received more than 30 days after the date of service will not be approved, and the service will remain a non-covered benefit.</p> <p>Tier 1 benefits are not guaranteed.</p>
<b>If your child needs dental or eye care</b>	Children's eye exam	Covered in Full	Covered in Full	Not Covered	Preventive care includes visual screening assessment, as covered under preventive services. (Recommended by Bright Futures Project).
	Children's glasses	Not Covered	Not Covered	Not Covered	Excluded Service.
	Children's dental check-up	Covered in Full	Covered in Full	Not Covered	Preventive care includes oral health risk assessment, as covered under preventive services. (Recommended by Bright Futures Project).

**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   | • Hearing Aids                                       | • Private-duty nursing     |
| • Bariatric surgery   | • Infertility treatment                              | • Routine Eye Exam (Adult) |
| • Cosmetic Surgery  | • Long-term care                                     | • Routine foot care        |
| • Dental care (except for treatment to sound natural teeth required due to injury.) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs     |

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

- |                     |                        |                   |
|---------------------|------------------------|-------------------|
| • Chiropractic Care | • Routine Hearing Exam | • Specialty Drugs |
| • Dialysis          |                        |                   |

**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 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa). 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**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 1-877-405-2926.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-405-2926.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-405-2926.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-405-2926.

—————*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>	\$3,500
■ <a href="#">Specialist</a> Copayment	\$50
■ 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 tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,360</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>	\$3,500
■ <a href="#">Specialist</a> Copayment	\$50
■ 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 tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,220</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>	\$3,500
■ <a href="#">Specialist</a> Copayment	\$50
■ 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,100
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,500</b>