



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 866-222-8207. 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 866-222-8207 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| <a href="#">What is the overall deductible?</a>                             | <p><a href="#">Network providers:</a><br/> <b>\$2,500</b>/individual,<br/> <b>\$3,300</b>/individual on Family Coverage or <b>\$4,500</b>/family</p> <p><a href="#">Out-of-network provider:</a><br/> <b>\$6,500</b>/individual,<br/> <b>\$6,500</b>/individual on Family Coverage or <b>\$12,500</b>/family</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. The <a href="#">deductible</a> is <b>Embedded</b>. 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>Deductible year runs 01/01 – 12/31</b></p>         |
| <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>              | <p><a href="#">Network providers:</a><br/> <b>\$3,000</b> /individual,<br/> <b>\$3,300</b>/individual on Family Coverage or <b>\$5,000</b> /family</p> <p><a href="#">Out-of-network providers:</a><br/> <b>\$19,000</b> /individual,<br/> <b>\$19,000</b>/individual on Family Coverage or <b>\$37,000</b>/family</p> | 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>Embedded</b> . 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.  |
| <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  | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |

|  |   |  |
|--|---|--|
|  | cover.  |  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>   | Yes. See <a href="http://www.CentralpedBenefits.com">www.CentralpedBenefits.com</a> or call 866-222-8207 for a list of <u>network providers</u> . | This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b> | No.   | You can see the <u>specialist</u> you choose without a <u>referral</u> .   |



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) |   |
| <b>If you visit a health care provider's office or clinic</b>  | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u>   | 50% <u>coinsurance</u>                          | None.   |
|  | <u>Specialist</u> visit                          | 20% <u>coinsurance</u>   | 50% <u>coinsurance</u>                          | None.   |
|  | <u>Preventive care/screening/immunization</u>    | No charge  | 50% <u>coinsurance</u>                          | 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. |
| <b>If you have a test</b>  | <u>Diagnostic test</u> (x-ray, blood work)       | 20% <u>coinsurance</u>   | 50% <u>coinsurance</u>                          | None.   |
|  | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>   | 50% <u>coinsurance</u>                          | May require <u>preauthorization</u> .   |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.CentralpedBenefits.com">www.CentralpedBenefits.com</a> | Generic drugs                                    | 30-day supply Retail: 20% <u>coinsurance</u><br>90-day supply Mail Order: 20% <u>coinsurance</u> |   | <u>Cost sharing</u> does not apply for <u>preventive Prescriptions</u> . <u>Deductible</u> does not apply to <u>copayment</u> . Retail & Mail Order available up to a 90-day supply.    |
|  | Preferred brand drugs                            | 30-day supply Retail: 20% <u>coinsurance</u><br>90-day supply Mail Order: 20% <u>coinsurance</u> |   |   |
|  | Non-preferred Brand drugs                        | 30-day supply Retail: 20% <u>coinsurance</u><br>90-day supply Mail Order: 20% <u>coinsurance</u> |   |   |
|  | <u>Specialty drugs</u>                           | 30-day supply Retail: Not Covered.   |   | None.   |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>   | 50% <u>coinsurance</u>                          | May require <u>preauthorization</u> .   |
|  | Physician/surgeon fees                           | 20% <u>coinsurance</u>   | 50% <u>coinsurance</u>                          |   |
| <b>If you need immediate medical attention</b>   | <u>Emergency room care</u>                       | 20% <u>coinsurance</u>   | 50% <u>coinsurance</u>                          | True emergency covered at in-network level.   |
|  | <u>Emergency medical transportation</u>          | 20% <u>coinsurance</u>   | 50% <u>coinsurance</u>                          | True emergency covered at in-network level.   |
|  | <u>Urgent care</u>                               | 20% <u>coinsurance</u>   | 50% <u>coinsurance</u>                          | None.   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)               | 20% <u>coinsurance</u>   | 50% <u>coinsurance</u>                          | <u>Preauthorization</u> required.   |

| 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) |   |
|   | Physician/surgeon fees                    | 20% <a href="#">coinsurance</a>           | 50% <a href="#">coinsurance</a>                 | None.   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 20% <a href="#">coinsurance</a>           | 50% <a href="#">coinsurance</a>                 | None.   |
|   | Inpatient services                        | 20% <a href="#">coinsurance</a>           | 50% <a href="#">coinsurance</a>                 | <a href="#">Preauthorization</a> required.  |
| If you are pregnant   | Office visits                             | No charge                                 | 50% <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. |
|   | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a>           | 50% <a href="#">coinsurance</a>                 |   |
|   | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>           | 50% <a href="#">coinsurance</a>                 | Maternity care may include tests and services described elsewhere in the SBC.   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>           | 50% <a href="#">coinsurance</a>                 | <a href="#">Preauthorization</a> required.<br>100 visits per plan year maximum.   |
|   | <a href="#">Rehabilitation services</a>   | 20% <a href="#">coinsurance</a>           | 50% <a href="#">coinsurance</a>                 | Occupational Therapy: No visit limit.<br>Speech Therapy: No visit limit.<br>Physical Therapy: No visit limit.   |
|   | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a>           | 50% <a href="#">coinsurance</a>                 |   |
|   | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>           | 50% <a href="#">coinsurance</a>                 | <a href="#">Preauthorization</a> required.<br>60 days per year maximum  |
|   | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>           | 50% <a href="#">coinsurance</a>                 | None.   |
|   | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a>           | 50% <a href="#">coinsurance</a>                 | <a href="#">Preauthorization</a> required.  |
| If your child needs dental or eye care                                    | Children's eye exam                       | No Charge                                 | 50% <a href="#">coinsurance</a>                 | 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)
- Hearing Aids
- 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)
- Emergency care when traveling outside the U.S.

- Routine Eye Care (one visit/yr covered at no cost for children under the age of 19)
- 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 866-222-8207]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-222-8207]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 866-222-8207]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 866-222-8207]

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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>   | \$2,500 |
| ■ <a href="#">Specialist</a> <a href="#">Coinsurance</a>          | 20%     |
| ■ <a href="#">Hospital (facility)</a> <a href="#">Coinsurance</a> | 20%     |
| ■ <a href="#">Other</a> <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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing |         |
|--------------|---------|
| Deductibles  | \$2,500 |
| Copayments   | \$0     |
| Coinsurance  | \$500   |

#### What isn't covered

|                                   |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,060</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>   | \$2,500 |
| ■ <a href="#">Specialist</a> <a href="#">Coinsurance</a>          | 20%     |
| ■ <a href="#">Hospital (facility)</a> <a href="#">Coinsurance</a> | 20%     |
| ■ <a href="#">Other</a> <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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing |         |
|--------------|---------|
| Deductibles  | \$2,500 |
| Copayments   | \$0     |
| Coinsurance  | \$500   |

#### What isn't covered

|                                   |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$3,020</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>   | \$2,500 |
| ■ <a href="#">Specialist</a> <a href="#">Coinsurance</a>          | 20%     |
| ■ <a href="#">Hospital (facility)</a> <a href="#">Coinsurance</a> | 20%     |
| ■ <a href="#">Other</a> <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> |
|---------------------------|----------------|

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

| Cost Sharing |         |
|--------------|---------|
| Deductibles  | \$2,500 |
| Copayments   | \$0     |
| Coinsurance  | \$60    |

#### What isn't covered

|                                   |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,560</b> |

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