



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, contact your Human Resources department. 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.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers \$4,000 Individual / \$8,000 Family; For out-of-network providers \$4,500 Individual / \$9,000 Family	Generally, you must pay all of the costs from providers up to the calendar year 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 and primary care services 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For network providers \$5,800 Individual / \$11,600 Family For out-of-network providers \$11,600 Individual / \$23,200 Family	The out-of-pocket limit is the most you could pay in a calendar 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 ?	Premiums , balance-billed charges, ineligible charges 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. You have a choice of Network. See www.consociate.com or call 1-877-752-3937 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 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 [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	\$30 copayment	40% coinsurance	Virtual visits covered as any other office visit.
	Specialist visit	\$60 copayment	40% coinsurance	
	Preventive care/screening/immunization	No Charge	40% coinsurance	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)	Office Setting: PCP: \$30 copayment SPC: \$60 copayment Outpatient Setting: 30% coinsurance	40% coinsurance	
	Imaging (CT/PET scans, MRIs)	30% coinsurance ,	40% coinsurance	Preauthorization is required for CT for non-orthopedic, MRI for non-orthopedic, PET.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medone-rx.com .	Generic drugs	30-day supply: \$8 copayment 60-day supply: \$16 copayment 90-day supply: \$24 copayment	Not Covered	Covers up to: Retail: 30, 60 or 90-day supply Mail Order: 90-day supply
	Preferred brand drugs	30-day supply: \$40 copayment 60-day supply: \$80 copayment 90-day supply: \$120 copayment		
	Non-preferred brand drugs	30-day supply: \$60 copayment 60-day supply: \$120 copayment 90-day supply: \$180 copayment		
	Specialty drugs	Managed by RxAllly through MedOne		Please call RxAllly at 877-794-2218.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	Preauthorization is required for certain outpatient procedures.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care - True emergency	\$500 copayment		Precertification is required if admitted. Copoly waived if admitted.
	Emergency room care - Non-emergency	\$500 copayment		
	Emergency medical transportation	30% coinsurance , In Network deductible applies		Inter-facility Air transport must be pre-certified through Sentinel Air Medical Alliance at 1-877-542-8828.
	Urgent care	\$30 copayment	40% coinsurance	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.consociatehealth.com.

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 have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	Precertification is required.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office Visit	\$30 copayment	40% coinsurance	Virtual visits covered as any other office visit.
	Outpatient services	30% coinsurance	40% coinsurance	Precertification is required for all inpatient services, and for intensive outpatient/partial hospitalization programs.
	Inpatient services	30% coinsurance	40% coinsurance	
If you are pregnant	Office visits	No Charge	40% coinsurance	Cost sharing does not apply to certain 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). Covered for dependent daughter. Precertification is required for some maternity hospital stays.
	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	Precertification is required. Limited to 90 days per calendar year.
	Rehabilitation services	\$30 copayment	40% coinsurance	Habilitation services for learning Disabilities are not covered.
	Habilitation services	\$30 copayment	40% coinsurance	
	Skilled nursing care	30% coinsurance	40% coinsurance	Precertification is required. Coverage is limited to 90 days per calendar year.
	Durable medical equipment	30% coinsurance	40% coinsurance	Preauthorization is required for electric /motorized scooters or wheelchairs and pneumatic compression devices.
	Hospice services	30% coinsurance	40% coinsurance	Precertification is required for inpatient services.
If your child needs dental or eye care	Children's eye exam	Not Covered		None
	Children's glasses	Not Covered		None
	Children's dental check-up	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](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- 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
- Non-emergency care when traveling outside the U.S.

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: Consociate Health: 1-800-798-2422. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. 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: Consociate Health: 1-800-798-2422. You can 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 1-800-798-2422

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-798-2422

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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](#) \$4,000
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$4,000
Copayments	\$0
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$5,800

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$4,000
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,500

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$4,000
- [ER copayment](#) \$500
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$2,300
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800


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



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, contact your Human Resources department. 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.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers \$5,000 Individual / \$10,000 Family; For out-of-network providers \$7,000 Individual / \$14,000 Family Maximum that any one person will satisfy toward the annual family deductible: \$5,000 Individual / \$7,000 Family	Generally, you must pay all of the costs from providers up to the calendar year 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 services 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For network providers \$6,900 Individual / \$13,800 Family For out-of-network providers \$14,000 Individual / \$28,000 Family Maximum that any one person will satisfy toward the annual family out of pocket limit: \$6,900 Individual / \$14,000 Family	The out-of-pocket limit is the most you could pay in a calendar 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 ?	Premiums , balance-billed charges, ineligible charges 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. You have a choice of Network. See www.consociate.com or call 1-877-752-3937 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 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

 All [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	20% coinsurance	40% coinsurance	Virtual visits covered as any other office visit.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/immunization	No Charge	40% coinsurance	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	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization is required for CT for non-orthopedic, MRI for non-orthopedic, PET.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medone-rx.com .	Generic drugs	20% coinsurance	Not Covered	Covers up to: Retail: 30-day supply Mail Order: 90-day supply
	Preferred brand drugs	20% coinsurance		
	Non-preferred brand drugs	20% coinsurance		
	Specialty drugs	Managed by RxAlly through MedOne		Please call RxAlly at 877-794-2218.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required for certain outpatient procedures.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care - True emergency	20% coinsurance , In Network deductible applies		Precertification is required if admitted.
	Emergency room care - Non-emergency	20% coinsurance , In Network deductible applies		
	Emergency medical transportation	20% coinsurance , In Network deductible applies		Inter-facility Air transport must be pre-certified through Sentinel Air Medical Alliance at 1-877-542-8828.

* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.consociatehealth.com](#).

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)	
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office Visit	20% coinsurance	40% coinsurance	Virtual visits covered as any other office visit.
	Outpatient services	20% coinsurance	40% coinsurance	Precertification is required for all inpatient services, and for intensive outpatient/partial hospitalization programs.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	No Charge	40% coinsurance	Cost sharing does not apply to certain 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). Covered for dependent daughter. Precertification is required for some maternity hospital stays.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Precertification is required. Limited to 90 days per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Habilitation services for learning Disabilities are not covered.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification is required. Coverage is limited to 90 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required for electric /motorized scooters or wheelchairs and pneumatic compression devices.
	Hospice services	20% coinsurance	40% coinsurance	Precertification is required for inpatient services.
If your child needs dental or eye care	Children's eye exam	Not Covered		None
	Children's glasses	Not Covered		None
	Children's dental check-up	Not Covered		None

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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)
- Hearing Aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- 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
- Non-emergency care when traveling outside the U.S.

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Does this [plan](#) meet the Minimum Value Standards? Yes

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Language Access Services:

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[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-798-2422

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$5,000
- [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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$1,540
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$6,540

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5,000
- [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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,500

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$5,000
- [ER 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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