



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-567-1371. 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 Optum at 1-855-567-1371 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not Applicable	
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a> or call 1-855-567-1371 for a list of <u>network providers</u>	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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	Not Covered	Not Covered	None
	<u>Specialist</u> visit	Not Covered	Not Covered	None
	<u>Preventive care/screening/immunization</u>	Not Covered	Not Covered	None
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Not Covered	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.[insert].com">www.[insert].com</a>	Generic drugs	Not Covered	Not Covered	None
	Preferred brand drugs	Not Covered	Not Covered	None
	Non-preferred brand drugs	Not Covered	Not Covered	None
	<u>Specialty drugs</u>	Not Covered	Not Covered	None
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	None
	Physician/surgeon fees	Not Covered	Not Covered	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	Not Covered	Not Covered	None
	<u>Emergency medical transportation</u>	Not Covered	Not Covered	None
	<u>Urgent care</u>	Not Covered	Not Covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not Covered	Not Covered	None
	Physician/surgeon fees	Not Covered	Not Covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$20 <u>Copayment</u> per visit	20% <u>Coinsurance</u>	None
	Inpatient services	Not Covered	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Not Covered	Not Covered	None
	Childbirth/delivery professional services	Not Covered	Not Covered	None
	Childbirth/delivery facility services	Not Covered	Not Covered	None
If you need help recovering or have other special health needs	<u>Home health care</u>	Not Covered	Not Covered	None
	<u>Rehabilitation services</u>	Not Covered	Not Covered	None
	<u>Habilitation services</u>	Not Covered	Not Covered	None
	<u>Skilled nursing care</u>	Not Covered	Not Covered	None
	<u>Durable medical equipment</u>	Not Covered	Not Covered	None
	<u>Hospice services</u>	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	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 <u>Plan</u> Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Long-term care</li> <li>• Infertility Treatment</li> <li>• Private-duty nursing</li> <li>• Substance Use Disorder Detoxification</li> <li>• Substance Use Disorder Subacute Residential</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine eye care (Adult)</li> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> <li>• Mental Health Inpatient</li> <li>• Substance Use Disorder Inpatient</li> <li>• Intensive Outpatient Program</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> <li>• Chiropractic Care</li> <li>• Hearing Aids</li> <li>• Mental Health Subacute Residential</li> <li>• Partial Hospitalization</li> <li>• Applied Behavior Analysis</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)
<ul style="list-style-type: none"> <li>• Not applicable</li> </ul>

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

**Does this plan provide Minimum Essential Coverage? No**

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? No**

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 1-866-556-8166

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-556-8166

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-556-8166

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-556-8166

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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 plan's overall deductible N/A
- Specialist coinsurance N/A
- Hospital (facility) coinsurance N/A
- Other coinsurance N/A

**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>	
<u>Deductibles</u>	N/A
<u>Copayments</u>	N/A
<u>Coinsurance</u>	N/A
<i>What isn't covered</i>	
Limits or exclusions	\$12,700
<b>The total Peg would pay is</b>	<b>\$12,700</b>

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible N/A
- Specialist coinsurance N/A
- Hospital (facility) coinsurance N/A
- Other coinsurance N/A

**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>	
<u>Deductibles</u>	N/A
<u>Copayments</u>	N/A
<u>Coinsurance</u>	N/A
<i>What isn't covered</i>	
Limits or exclusions	\$5,600
<b>The total Joe would pay is</b>	<b>\$5,600</b>

### Mia's Simple Fracture

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

- The plan's overall deductible N/A
- Specialist coinsurance N/A
- Hospital (facility) coinsurance N/A
- Other coinsurance N/A

**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>	
<u>Deductibles</u>	N/A
<u>Copayments</u>	N/A
<u>Coinsurance</u>	N/A
<i>What isn't covered</i>	
Limits or exclusions	\$2,800
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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