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: $1,500 Individual /$3,000 Family; For out-of-network providers: $1,750 Individual / $3,500 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 services with a copayment 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: $5,500 Individual / $9,000 Family For out-of-network providers: $6,250 Individual / $10,000 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, penalties for failure to obtain precertification, 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	50% coinsurance	Virtual visits covered as any other office visit.
	Specialist visit	$50 copayment	50% coinsurance	
	Preventive care/screening/ immunization	No Charge, no deductible applies	50% 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. ***NOTE:*** Deductible does not apply to Out of Network Preventive care, screenings & immunizations for children up age 7.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% 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	Retail or Mail Order: 1-31 days: $5 copayment 31-60 days: $10 copayment 61-90 days: $15 copayment	Not Covered	Covers up to 31, 60 and 90-day supply at retail or through mail order.
	Preferred brand drugs	Retail or Mail Order: 1-31 days: $50 copayment 31-60 days: $100 copayment 61-90 days: $150 copayment		
	Non-preferred brand drugs	Retail or Mail Order: 1-31 days: $85 copayment 31-60 days: $70 copayment 61-90 days: $225 copayment		
	Specialty drugs	Available through MedOne's RxAlly program.	Not Covered	Please call RxAlly at 877-794-2218.
	Prescription Drug assistance through RxAlly is offered as part of your plan's prescription drug coverage. RxAlly Patient Care Coordinators will help you pursue drug manufacturer assistance programs and/or patient assistance programs. With many of these programs, your responsibility toward your prescription drug copay may be reduced or eliminated altogether. Coverage for certain prescription drugs may be available under the prescription drug benefit if RxAlly Coordinators are unable to obtain assistance programs for eligible Prescription Drugs. For help in acquiring Specialty Prescription Drug assistance, information about the RxAlly Program, or a list of eligible drugs, please call RxAlly at 877-794-2218.			

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization is required for certain outpatient procedures.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care - True emergency	$300 copayment per visit for facility: 30% coinsurance for physician, no deductible applies		Precertification is required if admitted. Copay waived if admitted.
	Emergency room care - Non-emergency	$300 copayment per visit for facility: 30% coinsurance for physician, no deductible applies		Precertification is required if admitted. Copay waived if admitted.
	Emergency medical transportation	30% coinsurance after Network deductible		Inter-facility Air transport must be pre-certified through Sentinel Air Medical Alliance at 1-877-542-8828.
	Urgent care	$50 copayment	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Precertification is required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office Visit	$30 copayment	50% coinsurance	Virtual visits covered as any other office visit.
	Outpatient services	30% coinsurance	50% coinsurance	Precertification is required for all inpatient services, and for intensive outpatient/partial hospitalization programs.
	Inpatient services	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	No Charge, no deductible applies	50% 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). Dependent daughter pregnancy is covered. Precertification is required for some maternity hospital stays.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Precertification is required.
	Rehabilitation services	30% coinsurance	50% coinsurance	Physical, Occupational and Speech Therapies are limited to 60 Maximum visits per calendar year combined. Habilitation services for learning disabilities are not covered.
	Habilitation services	30% coinsurance	50% coinsurance	

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 need help recovering or have other special health needs	Skilled nursing care	30% coinsurance	50% coinsurance	Precertification is required. Coverage is limited to 100 days per calendar year.
	Durable medical equipment	30% coinsurance	50% coinsurance	Preauthorization is required for electric /motorized scooters or wheelchairs and pneumatic compression devices.
	Hospice services	30% coinsurance	50% 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
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids (in network only)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (if medically necessary)

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

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, kwiijigo 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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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	**$1,500**
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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$3,360
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,860**

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

The plan's overall deductible	**$1,500**
Specialist copayment	**$50**
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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$500
Coinsurance	$0
What isn't covered	
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	**$1,500**
ER copayment	**$300**
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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$300
Coinsurance	$390
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,190**

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