|  |
| --- |
| **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**. The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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 425-313-2600. For general definitions of common terms, such as [allowed amount](https://www.healthcare.gov/sbc-glossary/#allowed-amount), [balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing), [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance), [copayment](https://www.healthcare.gov/sbc-glossary/#copayment), [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider](https://www.healthcare.gov/sbc-glossary/#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 425-313-2600 to request a copy. |

|  |  |  |
| --- | --- | --- |
| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | **$2,000** employee only/**$4,000** employee plus dependents for Preferred and Participating Networks.  **$4,000** employee only / **$8,000** employee plus dependents for Out-of-Network. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | **Yes.** Breast pumps, Cologuard preventive, flu shots and immunization for all Networks. Preventive care & services for Preferred and Participating Networks. | 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**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | **No.** There are no other specific deductibles. | You don’t have to meet deductibles for specific services. |
| **What is the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | **$5,000** employee only coverage / **$7,350** per individual with employee plus dependent coverage / **$10,000** per family with employee plusdependent coverage for Preferred and Participating Networks.  **$10,000** employee only coverage **/ $20,000** per individual or family with employee plus dependent coverage for Out-of-Network. Includes Pharmacy. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. |
| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | Penalties, ineligible charges, premiums, balance-billed 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**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. See [www.accesshma.com](http://www.accesshma.com) or call 1-800-700-7153 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**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | No. | You can see the specialist you choose without a referral. |

| **Exclamation** | All [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) applies. |
| --- | --- |

| **Common  Medical Event** | **Services You May Need** | **What You Will Pay** | | **Limitations, Exceptions, & Other Important Information** |
| --- | --- | --- | --- | --- |
| **Preferred or Participating Provider**  **(You will pay the least)** | **Out-of-Network Provider (You will pay the most)** |
| **If you visit a health care** [**provider’s**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | 20% coinsurance | 40% coinsurance | –––––––––none––––––––– |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | 20% coinsurance | 40% coinsurance | –––––––––none––––––––– |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/  immunization | No charge, deductible does not apply | Not covered | Out-of-Network breast pumps, flu shots and immunizations are covered at no charge, deductible does not apply. 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](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | 20% coinsurance | 40% coinsurance | –––––––––none––––––––– |
| Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | –––––––––none––––––––– |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at [www.express-scripts.com](http://www.express-scripts.com) | Generic drugs | 20% coinsurance | | Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). See Plan Document for non-use of generic drug penalty. |
| Preferred brand drugs | 20% coinsurance | |
| Non-preferred brand drugs | 20% coinsurance | |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | Same as retail schedule above | | Please contact Express Scripts, your specialty pharmacy, for more information on what is covered. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Preauthorization is required. |
| Physician/surgeon fees | 20% coinsurance | 40% coinsurance | –––––––––none––––––––– |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | 20% coinsurance | 20% coinsurance | –––––––––none––––––––– |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | 20% coinsurance | 20% coinsurance | –––––––––none––––––––– |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | 20% coinsurance | 20% coinsurance | –––––––––none––––––––– |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization is required. |
| Physician/surgeon fees | 20% coinsurance | 40% coinsurance | –––––––––none––––––––– |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 40% coinsurance | Preauthorization is required for partial hospitalization and intensive outpatient. |
| Inpatient services | 20% coinsurance | 40% coinsurance | Preauthorization is required. Residential treatment is covered. |
| **If you are pregnant** | Office visits | 20% coinsurance | 40% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | –––––––––none––––––––– |
| Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be preauthorized at the time your provider recommends the extended stay. |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | 20% coinsurance | 40% coinsurance | Preauthorization is required. Limited to a 130-visit calendar year maximum. |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | 20% coinsurance | 40% coinsurance | Preauthorization is required for inpatient and is limited to a 30-day calendar year maximum. Outpatient is limited to a 45-visit calendar year maximum. An additional 30 days (inpatient) and 80 visits (outpatient) are allowed for the treatment of stroke, head, or spinal cord injuries. Swim therapy is covered. Outpatient for autism related rehabilitation is no maximum. |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | Not covered | Not covered | Neurodevelopmental therapy is covered under outpatient rehabilitation with no age limit. |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | 20% coinsurance | 40% coinsurance | Preauthorization is required. Limited to a 120-day calendar year maximum. |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | 20% coinsurance | 40% coinsurance | Preauthorization is required for equipment over $2,000. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | 20% coinsurance | 40% coinsurance | Preauthorization is required. Limited to 14 inpatient days. Limited to 240 respite hours every 6-months. |
| **If your child needs dental or eye care** | Children’s eye exam | Not covered | | Refer to Vision Reimbursement Plan details. |
| Children’s glasses | Not covered | | Refer to Vision Reimbursement Plan details. |
| Children’s dental check-up | Not covered | | Refer to Dental Plan details. |

**Excluded Services & Other Covered Services:**

|  |  |  |
| --- | --- | --- |
| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | |
| * Bariatric surgery * Cosmetic surgery * Dental care (Adult) * Habilitation services | * Hearing aids * Infertility treatment * Long-term care * Non-emergency care when traveling outside the U.S. | * Private-duty nursing * Routine eye care (Adult) * Routine foot care (except diabetes) * Weight loss programs |

|  |  |  |
| --- | --- | --- |
| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** | | |
| * Acupuncture (20-visit yearly limit) | * Chiropractic care (20-visit yearly limit) |  |

**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: Everything Benefits, (800) 689-3568, and the 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](https://www.healthcare.gov/sbc-glossary/#marketplace). For more information about the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/#claim). This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal](https://www.healthcare.gov/sbc-glossary/#appeal). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](https://www.healthcare.gov/sbc-glossary/#claim). Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information to submit a [claim](https://www.healthcare.gov/sbc-glossary/#claim), [appeal](https://www.healthcare.gov/sbc-glossary/#appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/#plan). For more information about your rights, this notice, or assistance, contact: 1-800-700-7153, and the 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](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) generally includes [plans](https://www.healthcare.gov/sbc-glossary/#plan), [health insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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,](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) you may not be eligible for the [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits).

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard), you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace).

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-700-7153.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-700-7153.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-700-7153.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-700-7153.]

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

Exclamation

**About these Coverage Examples:**

**Peg is Having a Baby**(9 months of in-network pre-natal care and a hospital delivery)

**This is not a cost estimator.** Treatments shown are just examples of how this [plan](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles](https://www.healthcare.gov/sbc-glossary/#deductible), [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). Please note these coverage examples are based on self-only coverage.

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$2,000**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#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** |

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

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $0 |
| Coinsurance | $2,120 |
| *What isn’t covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,180** |

**Managing Joe’s type 2 Diabetes**(a year of routine in-network care of a well-controlled condition)

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$2,000**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#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**  **The plan would be responsible for the other costs of these EXAMPLE covered services.** |

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

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $0 |
| Coinsurance | $610 |
| *What isn’t covered* | |
| Limits or exclusions | $140 |
| **The total Joe would pay is** | **$2,750** |

**Mia’s Simple Fracture**(in-network emergency room visit and follow up care)

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$2,000**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) **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** |

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

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $00 |
| Coinsurance | $160 |
| *What isn’t covered* | |
| Limits or exclusions | $00 |
| **The total Mia would pay is** | **$2,160** |