



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, www.myelaracaringbenefits.com. 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 1-866-920-1963 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Preferred Provider : \$1,750/individual or \$3,500/family per calendar year. Nonpreferred Provider : None.	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 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. Prescription drugs , and the following services by a preferred provider : Preventive care , emergency room care , urgent care , rehabilitative services , habilitative services , specialist , and primary care physician 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 ?	Preferred Provider : \$4,500/individual or \$9,000/family per calendar year. Nonpreferred Provider : None.	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 , 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 ?	Penalties for failure to obtain preauthorization for services, premiums , balance-billing 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 .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.myelaracaringbenefits.com or call 1-866-920-1963 for a list of network providers .	This plan uses a provider network . You will pay less if you use a Preferred Provider in the plan's network . You will pay the most if you use a Nonpreferred 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 Preferred Provider might use a Nonpreferred 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 [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
		Preferred Provider (You will pay the least)	Nonpreferred 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 (deductible does not apply)	Not covered	P360 Teledoc covered at 0% coinsurance (deductible does not apply)
	Specialist visit	\$50 copayment (deductible does not apply)	Not covered	Chiropractic care limited to 35 visits per benefit period.
	Preventive care/screening /immunization	0% coinsurance (deductible does not apply)	Not covered	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	Not covered	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Pre-certification is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-script.com .	Generic drugs	Retail: \$15 copayment (deductible does not apply) Mail order: \$30 copayment (deductible does not apply)	Retail: Not covered Mail order: Not covered	Copay applies to a 30-day supply Retail and Specialty drugs or 31–90-day supply Mail-Order prescription. Copay does not apply to preventive drugs required by the Affordable Care Act.
	Preferred drugs	Retail: \$45 copayment (deductible does not apply) Mail order: \$90 copayment (deductible does not apply)	Retail: Not covered Mail order: Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
	Non-preferred drugs	Retail: \$75 copayment (deductible does not apply) Mail order: \$150 copayment (deductible does not apply)	Retail: Not covered Mail order: Not covered	
	Specialty drugs	Retail: \$350 copayment (deductible does not apply) Mail order: \$350 copayment (deductible does not apply)	Retail: Not covered Mail order: Not covered	Specialty medications are limited to a 30-day supply, must be ordered from Accredo at 800-803-2523, require preauthorization and quantity limits and/or step therapy may apply; (deductible does not apply)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Pre-certification is required for Outpatient Surgery.
	Physician/surgeon fees	20% coinsurance	Not covered	None.
If you need immediate medical attention	Emergency room care	\$300 copayment (deductible does not apply)	Preferred Provider benefit applies	Copay waived if admitted. Non-emergency 20% coinsurance after \$300 copayment (deductible does not apply)
	Emergency medical transportation	20% coinsurance	Preferred Provider benefit applies	None.
	Urgent care	\$50 copayment (deductible does not apply)	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Pre-certification is required.
	Physician/surgeon fees	20% coinsurance	Not covered	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance (deductible does not apply)	Not covered	None.
	Inpatient services	0% coinsurance	Not covered	Pre-certification is required.
If you are pregnant	Office visits	\$30 copayment (deductible does not apply)	Not covered	Dependent daughters are covered for this benefit. Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	Pre-certification is required.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Home health care visits limited to 60 visits per benefit period. Pre-certification is required.
	Rehabilitation services	\$50 copayment (deductible does not apply)	Not covered	Physical, occupational, and speech therapy combined limited to 90 visits per benefit period. All other outpatient physical therapy services 20% coinsurance .
	Habilitation services	\$50 copayment (deductible does not apply)	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	Skilled nursing care limited to 25 days per benefit period. Pre-certification is required.
	Durable medical equipment	20% coinsurance	Not covered	Pre-certification is required for DME over \$1,500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
	Hospice services	20% coinsurance	Not covered	Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	0% coinsurance (deductible does not apply)	Not covered	None..
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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)	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • 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	• Habilitation services	• Hearing aids

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. 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: 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 1-866-920-1963.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-920-1963.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-920-1963.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-866-920-1963.

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	\$1,750
■ Specialist copayment	\$50
■ 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:

Cost Sharing	
Deductibles	\$1,750
Copayments	\$10
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,020

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,750
■ Specialist copayment	\$50
■ 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:

Cost Sharing	
Deductibles	\$300
Copayments	\$400
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,920

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,750
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*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:

Cost Sharing	
Deductibles	\$1,300
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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