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 visit www.healthscopebenefits.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 www.cciio.cms.gov or call 1-800-403-1094 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network:**$500** Individual, **$1,000** Family; Non-Network: **$2,000** Individual, **$4,000** Family	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, Preventive care is 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?	Network: **$7,900** Individual, **$15,800** Family; Non-Network: **Unlimited**.	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?	Premiums, penalties, amounts over Usual and Customary fees and excluded charges.	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. See www.healthscopebenefits.com or call 1-800-403-1094 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.

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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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay	50% coinsurance	None
	Specialist visit	$40 copay	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge	50% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	LabOne: No Charge; Other Labs: 20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	MRI, MRA, PET and CAT scans require pre-certification.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.LDIRx.com.	Generic drugs	Pharmacy: 15% coinsurance or $5 copay Mail Order: 15% coinsurance or $10 copay	Not Covered	The greater of the coinsurance or copay amount applies.
	Preferred brand drugs	Pharmacy: 15% coinsurance or $40 copay Mail Order: 15% coinsurance or $80 copay	Not Covered	
	Non-preferred brand drugs	Pharmacy: 15% coinsurance or $60 copay Mail Order: 15% coinsurance or $120 copay	Not Covered	
	Specialty drugs	15% coinsurance	Not Covered	Pre-certification is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay; then 20% coinsurance	$300 copay; then 50% coinsurance	Pre-certification is required for some surgical procedures.

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)	
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay; then 20% coinsurance	$200 copay; then 20% coinsurance	Copay is waived if patient is admitted to the Hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$30 copay; then 20% coinsurance	50% coinsurance	Copay and coinsurance is waived if patient is admitted to the Hospital.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay; then 20% coinsurance	$600 copay; then 50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	PCP visit: $20 copay or Specialist visit: $40 copay Other services: 20% coinsurance	50% coinsurance	None
	Inpatient services	$200 copay; then 20% coinsurance	$600 copay; then 50% coinsurance	None
If you are pregnant	Office visits	$20 copay; then 20% coinsurance	50% coinsurance	Limited to 2 ultrasounds per uncomplicated pregnancy
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 50 visits per year and a lifetime maximum benefit of $50,000
	Rehabilitation services	20% coinsurance	50% coinsurance	None
	Habilitation services	20% coinsurance	50% coinsurance	None
	Skilled nursing care	$200 copay; then 20% coinsurance	$600 copay; then 50% coinsurance	Limited to 120 days per year. Admission must be within 14 days of hospital confinement of at least 3 days.

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)	
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-certification is required for charges over $1,000.
	Hospice services	20% coinsurance	50% coinsurance	Bereavement counseling is limited to 15 visits.
If your child needs dental or eye care	Children's eye exam	No Charge	50% coinsurance	Limited to screening for children as part of the preventative benefit.
	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Hearing aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Acupuncture ($500 maximum per year, for smoking cessation only)
- Chiropractic Care
- Dental Care (Adult – treatment for accidental injury if completed within 12 months)
- Private Duty Nursing (Limited to 50 visits per year)
- Routine eye care (1 preventative exam per year for adults and children)

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: The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272. 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 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: HealthSCOPE Benefits at 1-800-403-1094.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-403-1094.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa1-800-403-1094.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-403-1094.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-403-1094.

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

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	$500
Specialist copay	$40
Hospital (facility) copay	$200
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$40
Coinsurance	$2,476
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,076**

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

The plan's overall deductible	$500
Specialist copay	$40
Hospital (facility) copay	$200
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	**$7,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$240
Coinsurance	$884
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,780**

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

The plan's overall deductible	$500
Specialist copay	$40
Hospital (facility) copay	$200
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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$120
Coinsurance	$320
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$940**

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