




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.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.healthcare.gov/sbc-glossary or call 1-800-596-5719 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network : \$500 Employee, \$1,000 Family; Non-network : \$4,000 Employee, \$8,000 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 (all providers), urgent care, office visits, Premise Health Clinic (visits and diagnostic tests), hospice services and bereavement counseling 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 ?	Network : \$2,000 Employee, \$4,000 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. Call 1-800-596-5719 or visit www.healthscopebenefits.com 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 don't need a referral to see a specialist .	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
		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	\$15 copay /visit	50% coinsurance	Copay applies per visit regardless of what services are rendered.
	Specialist visit	\$35 copay /visit	50% coinsurance	
	Preventive care/screening/ Immunization	No Charge	Routine Colonoscopy – 50% coinsurance All Other Services – No Charge	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)	10% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ProActRX.com	Generic drugs	<u>30-Day Retail:</u> 20% copay \$15 min/\$150 max <u>30-Day Preferred Pharmacy:</u> 10% copay \$10 min/\$75 max <u>90-Day ProAct Mail Order and 90 Day Supply Pharmacies:</u> 20% copay \$25 min/\$275 max	Not Covered	Deductible does not apply. Covers up to a 90-day supply (retail prescription). The copay applies per prescription. There is no charge or deductible for preventive drugs. Dispense as Written (DAW) provision applies. Specialty drugs must be obtained directly from the specialty pharmacy. Diabetic supplies are \$0 copay. The following is included: blood glucose monitoring, blood sugar testing supplies, lancets and lancet devices, syringes/needles, and alcohol swabs.
	Preferred brand drugs	<u>30-Day Retail:</u> 30% copay \$30 min/\$150 max <u>90-Day ProAct Mail Order and 90 Day Supply Pharmacies:</u> 30% copay	Not Covered	

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.healthscopebenefits.com.

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)	
		\$75 min/\$275 max		
	Non-preferred brand drugs	<u>30-Day Retail:</u> 40% copay \$50 min/\$150 max <u>90-Day ProAct Mail Order and 90 Day Supply Pharmacies:</u> 40% copay \$125 min/\$275 max	Not Covered	
	Specialty drugs	Paid the same as generic, preferred and non-preferred drugs	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	None
	Physician/surgeon fees	10% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	Emergency: 10% coinsurance Non-Emergency: 10% coinsurance	Emergency: 10% coinsurance Non-Emergency: 50% coinsurance	Non-participating providers paid at the participating provider level of benefits for emergency services.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	\$35 copay /visit	50% coinsurance	Copay applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	
If you need mental	Outpatient services	\$15 copay /visit	50% coinsurance	None

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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)	
health, behavioral health, or substance abuse services	Inpatient services	10% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service.
If you are pregnant	Office visits	10% coinsurance	50% coinsurance	Preauthorization is required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service. Cost sharing does not apply to preventive services from a participating provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense; therefore the family deductible amount may apply.
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service.
	Rehabilitation services	\$35 copay /visit	50% coinsurance	Physical, speech & occupational therapy limited to a combined maximum of 60 visits per year.
	Habilitation services	10% coinsurance	50% coinsurance	
	Skilled nursing care	10% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service.
	Durable medical equipment	10% coinsurance	50% coinsurance	Preauthorization is required for equipment rental over \$500 and purchase over \$1,500. If you don't get preauthorization , benefits could be reduced by 60% of the total cost of the service for network charges and 30% of the total cost of the service for non-network charges.

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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)	
	Hospice services	No Charge	50% coinsurance	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	Covered under stand-alone dental plan.

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 .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic Surgery • Dental Care 	<ul style="list-style-type: none"> • Infertility Treatment • Long Term Care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Bariatric Surgery • Chiropractic Care 	<ul style="list-style-type: none"> • Hearing Aids • Private Duty Nursing 	<ul style="list-style-type: none"> • Weight Loss Programs

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 1-800-596-5719.

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 1-800-596-5719

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-596-5719

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-596-5719

[Navajo (Dine): Dinek'ehgo shika a't'ohwol ninisingo, kwijigo holne' 1-800-596-5719

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](#) \$500
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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	\$500
Copayments	\$0
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,760

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 copayment](#) \$35
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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	\$500
Copayments	\$200
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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
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In this example, Mia would pay:

Cost Sharing

Deductibles	\$500
Copayments	\$200
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

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