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.healthgram.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 980-201-3020 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,000 individual/$3,000 family; for out-of-network providers $2,000 individual/$6,000 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, primary care services, urgent care, specialist visit and prescription drug coverage 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?	Yes. $250 in-network/$1,000 out-of-network per occurrence/per admission deductible for inpatient and outpatient facility.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $4,000 individual/$12,000 family; for out-of-network providers $8,000 individual/$24,000 family	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, 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.
Will you pay less if you use a network provider?	Yes. See www.healthgram.com or call 980-201-3020 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 **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 deductible does not apply	30% coinsurance	None
	Specialist visit	$35 copay/visit deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	30% 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.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance deductible does not apply	0% coinsurance deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance deductible does not apply	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 75% of the total cost of the service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pharmavail.com	Generic drugs	$10 copay/ prescription (retail) $30 copay/prescription (mail order) deductible does not apply	Not covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (retail and mail order prescription).
	Preferred brand drugs	$25 copay/prescription (retail) $75 copay/prescription (mail order) deductible does not apply	Not covered	
	Non-preferred brand drugs	$50 copay/prescription (retail) $125 copay/prescription (mail order) deductible does not apply	Not covered	
	Specialty drugs	Payable under the applicable retail tier	Not covered	Covers up to a 30-day supply (retail subscription)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance deductible does not apply	30% coinsurance deductible does not apply	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 75% of the

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)	
				total cost of the service.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay deductible does not apply	$200 copay deductible does not apply	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	In-Network deductible must be met prior to co-insurance benefits.
	Urgent care	$35 copay deductible does not apply	$35 copay deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance, additional per occurrence deductible $250	30% coinsurance, additional per occurrence deductible $1,000	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 75% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $25 copay/visit deductible does not apply 20% coinsurance	30% coinsurance	$25 copay will apply to services rendered in an office.
	Inpatient services	20% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 75% of the total cost of the service.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	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	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance, additional per occurrence deductible $250	30% coinsurance, additional per occurrence deductible $1,000	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 75% of the total cost of the service.
If you need help recovering or have other	Home health care	20% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 75% of the

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)	
special health needs				total cost of the service.
	Rehabilitation services	20% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 75% of the total cost of the service. $35 copay applies to in-network office visits. Physical and Occupational Therapy, calendar year maximum 30 visits. Speech and Hearing Therapy, calendar year maximum 30 visits.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	30% coinsurance	Limited to 60 days per year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 75% of the total cost of the service.
	Durable medical equipment	20% coinsurance	30% coinsurance	Preauthorization is required over $1,000. If you don't get preauthorization benefits will be reduced by 75% of the total cost of the service.
	Hospice services	20% coinsurance	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 75% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Payable at 100% after a $15 copay deductible does not apply	30% coinsurance	One exam per calendar year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	No charge	Calendar year max of $1,000

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
- Habilitation Services
- Long-term care
- Non-emergency care when traveling outside the US
- Private duty nursing
- Routine foot care
- Weight loss programs
- Dental care (Adult)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Acupuncture
- Hearing Aids
- Infertility treatment
- Routine eye care (Adult)

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: 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 x61565 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: Healthgram at 980-201-3020, or www.healthgram.com, or 1-866-444-EBSA (3272), or www.dol.gov/ebsa.

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: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 980-201-3020

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電980-201-3020

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	$1,000
Specialist copayment	$35
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	$1,000
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,170**

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

The plan's overall deductible	$1,000
Specialist copayment	$35
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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$800
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	$1,000
Specialist copayment	$35
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*	$1,000
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Healthgram.com.

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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