**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, go to www.MyCisionBenefits.com or call (833) 346-1479. 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 Care Coordinators at (833) 346-1479 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For participating providers: $2,500 person / $5,000 family<br>For non-participating providers: $4,000 person / $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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. For participating providers: 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 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?** | For participating providers: $4,000 person / $8,000 family<br>For non-participating providers: $8,000 person / $16,000 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.MyCisionBenefits.com or call: (833) 346-1479 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. |
| **Is a Health Savings Account (HSA) available under this plan option?** | Yes. | An HSA is an account that may be set up by you or your employer to help you plan for current and future health care costs. You may make contributions to the HSA up to a maximum amount set by the IRS. |

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 |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating 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% coinsurance | 50% coinsurance | See your plan document for any costs associated with the Teladoc programs. Includes telemedicine other than Teladoc. |
| | Specialist visit | 20% coinsurance | 50% coinsurance | |
| | Preventive care/screening/ immunization | No Charge | 50% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 50% coinsurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | Preauthorization recommended for MRI/MRA and PET scans. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.optumrx.com | Generic drugs | 10% copay ($25 maximum) for 34-day prescription (retail stores) /10% copay ($0 minimum/$50 maximum) for 90-day prescription at mail order or at CVS | 10% copay ($25 maximum) for 34-day prescription (retail stores) | Major medical deductible applies. Covers up to a 34-day supply (retail prescription); 90-day supply (mail order prescription or at CVS retail); 30-day supply (specialty drugs). The copay applies per prescription. After 2 fills at retail, maintenance drugs must be purchased as a 90-day supply at either a CVS retail pharmacy or through the mail order program. Specialty drugs must be obtained from the specialty pharmacy network. Step therapy provision applies. Certain women's preventive services will be covered with no cost to the member. |
| | Preferred brand drugs | 25% copay ($25 minimum/$75 maximum) for 34-day prescription (retail stores)/25% copay ($50 minimum/$150 maximum) for 90-day prescription at mail order or at CVS | 25% copay ($25 minimum/$75 maximum) for 34-day prescription (retail stores) | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Non-preferred brand drugs | 35% copay ($35 minimum/$125 maximum) for 34-day prescription (retail stores)/35% copay ($75 minimum/ $250 maximum) for 90-day prescription at mail order or at CVS | 35% copay ($35 minimum/$125 maximum) for 34-day prescription (retail stores) | Dispensing limits may apply to certain drugs |
| | Specialty drugs | Paid the same as generic, preferred brand and non-preferred brand drugs | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | Preauthorization recommended. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance (emergency services)/ 50% coinsurance (non-emergency services) | Non-participating providers paid at the participating provider level of benefits for emergency services. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Non-participating providers paid at the participating provider level of benefits. |
| | Urgent care | 20% coinsurance | 50% coinsurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | $500 copay/admission, then 50% coinsurance | Preauthorization recommended. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 50% coinsurance | You pay 20% of the consult fee after the deductible if you receive Teladoc behavioral health consultations. Includes telemedicine other than Teladoc. Preauthorization recommended for inpatient admissions and partial hospitalization and intensive outpatient care. |
| | Inpatient services | 20% coinsurance | $500 copay/admission, then 50% coinsurance (facility)/ 50% coinsurance (professional fees) | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If you are pregnant** | Office visits | 20% coinsurance | 50% coinsurance | Preauthorization recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). 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 | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | $500 copay/admission, then 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Limited to 60 visits per year. Preauthorization recommended. |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | Physical & occupational therapy limited to 90 visits per each type of therapy per year. Speech/hearing therapy limited to 30 visits per year. |
| | Habilitation services | 20% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 20% coinsurance | $500 copay/admission, then 50% coinsurance | Limited to 60 days per year. Preauthorization recommended. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Preauthorization recommended for rentals or purchase over $1,500. |
| | Hospice services | 20% coinsurance | $500 copay/admission, then 50% coinsurance (inpatient)/50% coinsurance (outpatient) | Bereavement counseling is covered if received within 6 months of death. Preauthorization recommended. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | Not Covered |
| | 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**
- **Cosmetic surgery**
- **Glasses (Adult & Child)**
- **Hearing aids (age 18 and over)**
- **Long-term care**
- **Non-emergency care when traveling outside the U.S.**
- **Private-duty nursing (inpatient)**
- **Routine eye care (Adult & Child)**
- **Routine foot care (except for diabetic, metabolic or peripheral vascular disease)**
- **Weight loss programs**

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • **Bariatric surgery (for morbid obesity only)**<br>• **Chiropractic care (30 visits per year)**<br>• **Dental care (Adult & Child - accidental dental care only)** | • **Hearing aids (1 hearing aid per ear every 3 years, up to age 18)**<br>• **Infertility treatment ($25,000 per lifetime – combine maximum with fertility medication through the prescription drug program)** | • **Private-duty nursing (outpatient - 95 visits per year)** |

**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 (866) 444-3272 or www.dol.gov/ebsa/healthreform or Care Coordinators at (833) 346-1479. 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 (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 the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform or Care Coordinators at (833) 346-1479.

Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance Office of Consumer Health Insurance, Consumer Services Section at (877) 527-9431.

**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 1-800-378-1179.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-378-1179.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

***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** | **$2,500** |
| **Primary care physician coinsurance** | **20%** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Primary care physician 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 | $2,500 |
| Copayments | $0 |
| Coinsurance | $1,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $4,060 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2,500** |
| **Specialist coinsurance** | **20%** |
| **Hospital (facility) coinsurance** | **20%** |
| **Other coinsurance** | **20%** |

**This EXAMPLE event includes services like:**
Specialist 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 | $2,500 |
| Copayments | $0 |
| Coinsurance | $700 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | $3,220 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2,500** |
| **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 | $2,500 |
| Copayments | $0 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $2,560 |

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