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 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, 1.888.816.3096. 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 1.888.816.3096 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall deductible ? | In-Network: \$300 Single/ \$600 Family Out-of-Network: \$300 Single/ \$600 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. Emergency room visits, preventive care and urgent care. | 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 ? | In-Network: \$1,500 Single/ \$3,000 Family Out-of-Network: \$2,500 Single/ \$5,000 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, plan deductible, copayments, penalties and healthcare 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. Call 1.888.816.3096 or visit www.healthplan.org for a list of participating 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 [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met.

| 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% coinsurance | 40% coinsurance | |
| | Specialist visit | 20% coinsurance | 40% coinsurance | |
| | Preventive care/screening/immunization | No charge (deductible waived) | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% - CAMC 20% - THP network | 40% coinsurance | Hospital other than CAMC – 25% coinsurance |
| | Imaging (CT/PET scans, MRIs) | 20% - CAMC 25% - THP network | 40% coinsurance | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ldirx.com | Generic drugs | \$5 plus 20% of balance | Not covered | Deductible \$50 single/\$100 family |
| | Preferred brand drugs | \$20 plus 20% of balance | Not covered | |
| | Non-preferred brand drugs | \$35 plus 20% of balance | Not covered | Brand with Generic Equivalent \$35 plus 20% of balance |
| | Specialty drugs | 20% with max \$100 (non-copay assistance) \$0 (copay assistance) | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% - CAMC 25% - THP network | 40% coinsurance | |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| If you need immediate medical attention | Emergency room care | \$50 copay/visit (deductible waived) 20% coinsurance after copay if non-emergent | \$50 copay/visit (deductible waived) 40% coinsurance after copay if non-emergent | True emergency. Copay waived if admitted. Non-emergencies subject to deductible. |
| | Emergency medical transportation | No charge (deductible waived) 20% after deductible (non-emergent) | No charge (deductible waived) 40% (non-emergent) | Emergency transportations only. Non-emergencies subject to deductible |
| | Urgent care | \$25 copay/visit (deductible waived) | \$25 copay/visit (deductible waived) | |
| If you have a hospital | Facility fee (e.g., hospital room) | 20% - CAMC | 40% coinsurance | Pre-certification required. |

* For more information about limitations and exceptions, see your Benefits Office for a copy of the plan or policy document.

| 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) | |
| stay | | 25% - THP network | | |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance | 40% coinsurance | |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Pre-certification required. |
| If you are pregnant | Office visits | 20% coinsurance | 40% coinsurance | Cost sharing does not apply for preventive services . |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% - CAMC 25% - THP network | 40% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | Limited to 120 days per calendar year. |
| | Rehabilitation services | 20% - CAMC 25% - THP network | 40% coinsurance | Physical and occupational therapy limited to 20 visits per calendar year combined. Visits beyond 20 are covered at 50%. |
| | Habilitation services | 20% - CAMC 25% - THP network | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Limited to 100 days per calendar year. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | |
| | Hospice services | 20% coinsurance | 40% coinsurance | |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | Refer to vision plan |
| | Children's glasses | Not covered | Not covered | Refer to vision plan |
| | Children's dental check-up | Not covered | Not covered | Refer to 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](#).)

- | | | |
|--|--|------------------------|
| • Acupuncture | • Hearing aids | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) - Except removal of impacted wisdom teeth. | • Non-emergency care when traveling outside the U.S. | • 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 | • Infertility treatment | • Routine eye care (Adult) – Vision coverage only. |
|---------------------|-------------------------|--|

* For more information about limitations and exceptions, see your Benefits Office for a copy of the plan or policy document.

Your Rights to Continue Coverage: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that certain *Participants* as specified below may elect to continue participation as a temporary extension of medical coverage (hereinafter “continuation coverage”) upon payment of monthly premium by *Participant* in certain instances where participation in the *Plan* would otherwise be terminated. It is the responsibility of an *Employee*, a participating *Spouse* of *Dependent* (hereinafter referred to as a “qualified beneficiary”) to notify the Human Resource Department in writing of any of the following events within sixty (60) days of the event:

1. Divorce of legal separation from the *Employee* or Retired Employee;
2. Parents' divorce or legal separation;
3. The dependent *Child* ceases to be a *Dependent* as defined;
4. A second qualifying event that occurs while on COBRA;
5. Notice that a qualified beneficiary is entitled to a disability extension; or
6. Notice that a qualified beneficiary is no longer disabled as determined by Social Security Administration.

Failure to notify the Human Resource Department as required will result in the forfeiture of the qualified beneficiary's (as applicable) rights to continuation coverage.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance you can contact The Health Plan Appeals Coordinator at 888.816.3093.

Does this plan provide Minimum Essential Coverage? Yes.

Does this plan meet the Minimum Value Standards? Yes.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1.855.577.7123.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.855.577.7123.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1.855.577.7123.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1.855.577.7123.

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

* For more information about limitations and exceptions, see your Benefits Office for a copy of the plan or policy document.

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](#) \$300
- [Specialist coinsurance](#) 20%
- 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 | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$300 |
| Copayments | \$0 |
| Coinsurance | \$1,500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$1,800 |

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$300
- [Specialist coinsurance](#) 20%
- 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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$300 |
| Copayments | \$0 |
| Coinsurance | \$530 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$830 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$300
- [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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$300 |
| Copayments | \$50 |
| Coinsurance | \$160 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$510 |