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 Brand with Generic Equivalent $35 plus 20% of balance
	Preferred brand drugs	$20 plus 20% of balance	Not covered	
	Non-preferred brand drugs	$35 plus 20% of balance	Not covered	
	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
- Cosmetic surgery
- Dental care (Adult) - Except removal of impacted wisdom teeth.
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- 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 of 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, kwiijigo 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:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$1,500
What isn't covered	
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:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$530
What isn't covered	
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:

Cost Sharing	
Deductibles	$300
Copayments	$50
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$510

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