




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](http://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 <a href="#">deductible</a> ?                                | For <a href="#">network providers</a> \$1,800 individual/\$3,600 family; for <a href="#">out-of-network providers</a> \$3,600 individual/\$7,200 family  | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .  | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | There are no other specific deductibles.   | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> \$4,000 individual/\$8,000 family; for <a href="#">out-of-network providers</a> \$8,000 individual/\$16,000 family | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                             | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.healthgram.com">www.healthgram.com</a> or call 980-201-3020 for a list of <a href="#">network providers</a> .               | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | 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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | None  |
|  | <a href="#">Specialist</a> visit                       | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | None  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge  | 40% <a href="#">coinsurance</a>                    | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | None  |
|  | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50%.   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.elixirsolutions.com">www.elixirsolutions.com</a> | Generic drugs  | \$10 <a href="#">copay</a> (retail)<br>\$30 <a href="#">copay</a> (maintenance)<br>\$30 <a href="#">copay</a> (mail order)   | Not covered  | Covers up to a 30-day supply (retail subscription); 31-90 day supply (retail and mail order prescription).  |
|  | Preferred brand drugs                                  | \$30 <a href="#">copay</a> (retail)<br>\$90 <a href="#">copay</a> (maintenance)<br>\$90 <a href="#">copay</a> (mail order)   | Not covered  |   |
|  | Non-preferred brand drugs                              | \$50 <a href="#">copay</a> (retail)<br>\$150 <a href="#">copay</a> (maintenance)<br>\$150 <a href="#">copay</a> (mail order) | Not covered  |   |
|  | <a href="#">Specialty drugs</a>                        | \$200 <a href="#">copay</a>  | Not covered  | Covers up to a 30-day supply (retail subscription).   |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)         | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50%.   |
|  | Physician/surgeon fees                                 | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>                    | None  |
| If you need immediate medical attention  | <a href="#">Emergency room care</a>                    | 20% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | In-Network deductible must be met prior to co-insurance benefits.   |
|  | <a href="#">Emergency medical</a>                      | 20% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    |   |

| Common Medical Event  | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|   | <a href="#">transportation</a>            |  |  |  |
|   | <a href="#">Urgent care</a>               | 20% <a href="#">coinsurance</a>              | 20% <a href="#">coinsurance</a>                    |  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50%.  |
|   | Physician/surgeon fees                    | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | None   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | None   |
|   | Inpatient services                        | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50%.  |
| If you are pregnant   | Office visits                             | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|   | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    |  |
|   | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50%.  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50%.  |
|   | <a href="#">Rehabilitation services</a>   | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | 90 combined visits per year for PT/OT/SP. Limitation does not apply to treatments for Autism/ABA Therapy.  |
|   | <a href="#">Habilitation services</a>     | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | Habilitation services are combined with the Rehabilitation service limits listed above.  |
|   | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50%. Coverage is limited to   |

| Common Medical Event   | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|--|---|--|--|---|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| If you need help recovering or have other special health needs |   |  |  | 90 days per year.   |
|  | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50%. |
|  | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    |   |
| If your child needs dental or eye care                         | Children's eye exam                       | Not covered                                  | Not covered  | None. See your Employer for benefit details.  |
|  | Children's glasses                        | Not covered                                  | Not covered  |   |
|  | Children's dental check-up                | 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
- Long-term care
- Dental care (Adult)
- Routine foot care
- Routine eye care (Adult)
- 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
- Infertility treatment
- Chiropractic care
- Non-emergency care when traveling outside the United States
- Hearing aids \$3,000 per year
- Private duty nursing
- Habilitation services

**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](http://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](http://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](http://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](http://www.healthgram.com), or 1-866-444-EBSA (3272), or [www.dol.gov/ebsa](http://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](#) \$1,800
- [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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,800        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$2,200        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,060</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,800
- [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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a> *     | \$1,800        |
| <a href="#">Copayments</a>        | \$400          |
| <a href="#">Coinsurance</a>       | \$100          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,320</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,800
- [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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a> *     | \$1,800        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$200          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,010</b> |

\*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.