




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, call 844-302-7774 . 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 844-302-7774 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	Not applicable.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not applicable.	This <a href="#">plan</a> does not have a <a href="#">deductible</a> .
Are there other <a href="#">deductibles</a> for specific services?	Not applicable.	This <a href="#">plan</a> does not have a <a href="#">deductible</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not applicable.	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> .
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not applicable.	This <a href="#">plan</a> does not have an <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://GeneralSecurityBenefits.com">GeneralSecurityBenefits.com</a> or call 844-302-7774 for a list of <a href="#">network providers</a> .	This plan 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> ).
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copayment</a>	Not Covered	None.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a>	Not Covered	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . 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)	X-ray - \$100 Copay Labs - \$50 Copay	Not Covered	Labs in a clinic or independent lab setting are covered at no charge.
	Imaging (CT/PET scans, MRIs)	\$500 <a href="#">copayment</a>	Not Covered	None.
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">GeneralSecurityBenefits.com</a>	Generic drugs	Retail: \$25/ <a href="#">Prescription</a> Mail Order: \$50/ <a href="#">Prescription</a>		<a href="#">Cost sharing</a> does not apply for <a href="#">preventive Prescriptions</a> . Retail and Mail ORder available up to a 90-day supply. 3 Prescription limit per month per member.
	Preferred brand drugs	Retail: \$50/ <a href="#">Prescription</a> Mail Order: \$100/ <a href="#">Prescription</a>		
	Non-preferred brand drugs	Retail & Mail Order: Not Covered		
	<a href="#">Specialty drugs</a>	Retail & Mail Order: Not Covered		None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$1,000 benefit per year	Not Covered	None.
	Physician/surgeon fees			
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$500 <a href="#">copayment</a>	Not Covered	None.
	<a href="#">Emergency medical transportation</a>	\$500 <a href="#">copayment</a>	Not Covered	None.
	<a href="#">Urgent care</a>	\$75 <a href="#">copayment</a>	Not Covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000 benefit per day	Not Covered	3 days per year maximum.
	Physician/surgeon fees			

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$50 <a href="#">copayment</a>	Not Covered	None.
	Inpatient services	\$1,000 benefit per day	Not Covered	None.
<b>If you are pregnant</b>	Office visits	No charge	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive</a> services. Depending on the type of services, a <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	\$1,000 benefit per day	Not Covered	
	Childbirth/delivery facility services	\$1,000 benefit per day	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not Covered	Not Covered	None.
	<a href="#">Rehabilitation services</a>	\$50 Copay	Not Covered	Occupational and Speech Therapy are not covered. Physical Therapy limited to 12 visits per year.
	<a href="#">Habilitation services</a>	\$50 Copay	Not Covered	
	<a href="#">Skilled nursing care</a>	\$1,000 benefit per day	Not Covered	None.
	<a href="#">Durable medical equipment</a>	Not Covered	Not Covered	None.
	<a href="#">Hospice services</a>	Not Covered	Not Covered	None.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	Limit of 1 routine exam per year.
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	None.

#### 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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- 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.)**

- [Preventive care](#)
- Chiropractic care
- Non-[Preventive care](#)
- 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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 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: : Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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?**

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 844-302-7774

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-302-7774

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-302-7774

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 844-302-7774

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

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$1,000
■ Other <a href="#">coinsurance</a>	100%

#### 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>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$2,440
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$8,260
<b>The total Peg would pay is</b>	<b>\$10,700</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$1,000
■ Other <a href="#">coinsurance</a>	100%

#### 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>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,410
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$3,560
<b>The total Joe would pay is</b>	<b>\$4,970</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$1,000
■ Other <a href="#">coinsurance</a>	100%

#### 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>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$800
<b>The total Mia would pay is</b>	<b>\$2,000</b>