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, www.lifetimebenefitsolutions.com or by calling 1-607-758-5530. 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 1-888-483-2123 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Major medical: $100 individual/ $300 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. Preventive care, Basic Benefits and prescription drug coverage are 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 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?	Major medical: $500 individual / $1,500 family; prescription drug coverage: $6,100 individual / $11,700 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.lifetimebenefitsolutions.com 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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	No Charge	100% to allowed amount	Some out-of-network services may not be covered. 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)	No Charge	100% to allowed amount	None
	Imaging (CT/PET scans, MRIs)	No Charge	100% to allowed amount	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.proactrx.com.	Generic drugs (Tier 1)	$10 copay/prescription (retail) $10 copay/prescription (mail order)		Note: Out-of-Network prescriptions are not covered. Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$20 copay/prescription (retail) $20 copay/prescription (mail order)		
	Non-preferred brand drugs (Tier 3)	$35 copay/prescription (retail) $35 copay/prescription (mail order)		
	Specialty drugs (Tier 4)	Applicable copay tier applies.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	100% to allowed amount	None
	Physician/surgeon fees	No Charge	100% to allowed amount	None
If you need immediate medical attention	Emergency room care	No Charge	100% to allowed amount	None
	Emergency medical transportation	No Charge	100% to allowed amount	None
	Urgent care	No Charge	100% to allowed amount	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	100% to allowed amount	None
	Physician/surgeon fees	No Charge	100% to allowed amount	None

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 need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	None
	Inpatient services	No Charge	100% to allowed amount	None
If you are pregnant	Office visits	No Charge	100% to allowed amount	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	100% to allowed amount	
	Childbirth/delivery facility services	No Charge	100% to allowed amount	
If you need help recovering or have other special health needs	Home health care	No Charge, first 40 visits under Basic Benefit. 20% coinsurance, 325 visit maximum under Major Medical Benefit.	100% to allowed amount, first 40 visits under Basic Benefit. 20% coinsurance, 325 visit maximum under Major Medical Benefit.	Limit: 365 visits/year.
	Rehabilitation services	No Charge if related to surgery or hospitalization; otherwise 20% coinsurance	100% to allowed amount if related to surgery or hospitalization; otherwise 20% coinsurance	Inpatient Rehabilitation Limit: 365 days per disability (2 days in SNF count as 1 in Hospital), maximum combined with habilitation services.
	Habilitation services	No Charge if related to surgery or hospitalization; or 20% coinsurance	100% to allowed amount if related to surgery or hospitalization; or 20% coinsurance	Inpatient Limit: 365 days/ disability (2 days in SNF count as 1 in Hospital), maximum combined with rehabilitation services.
	Skilled nursing care	No Charge	100% to allowed amount	Limit: 365 days per disability (2 days in SNF count as 1 in Hospital), maximum combined with rehabilitation and habilitation services.
	Durable medical equipment	20% coinsurance	20% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No Charge	20% coinsurance	Limit: 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	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
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long Term Care
- Routine Eye Care (Adult)
- 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.)

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Non-emergency care when traveling outside the U.S
- Private Duty Nursing

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: 1-877-267-2323 or 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 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: 1-877-833-2930.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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 1-877-833-2930.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-833-2930.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-833-2930.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-833-2930.

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	$100
Specialist cost sharing	20%
Hospital (facility) coinsurance	0%
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	$100
Copayments	$40
Coinsurance	$40
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$220

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

The plan's overall deductible	$100
Specialist cost sharing	20%
Hospital (facility) coinsurance	0%
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	$100
Copayments	$570
Coinsurance	$560
What isn't covered	
Limits or exclusions	$56
The total Joe would pay is	$1,290

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

The plan's overall deductible	$100
Specialist cost sharing	20%
Hospital (facility) coinsurance	0%
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	$100
Copayments	$0
Coinsurance	$110
Limits or exclusions	$0
The total Mia would pay is	$210

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