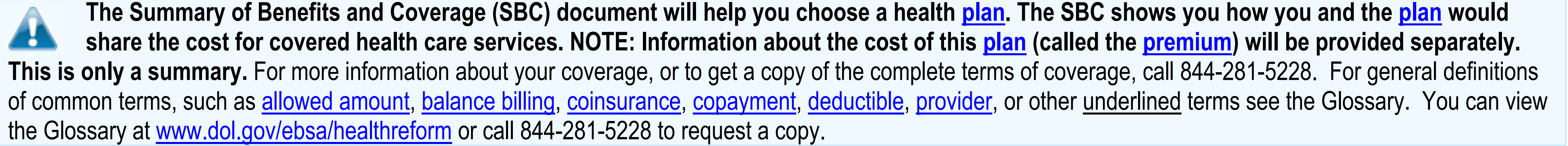
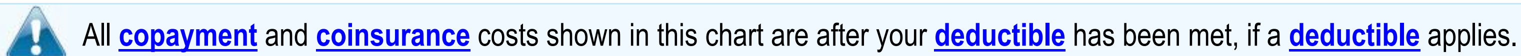


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 844-281-5228. 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 or call 844-281-5228 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable	This plan does not have a deductible.
Are there other deductibles for specific services?	Not applicable	This plan does not have a deductible.
What is the out-of-pocket limit for this plan?	Not applicable	This plan does not have an out-of-pocket limit.
What is not included in the out-of-pocket limit?	Not applicable	This plan does not have an out-of-pocket limit.
Will you pay less if you use a network provider?	Not applicable	This plan only covers preventive care.
Do you need a referral to see a specialist?	No.	This plan only covers preventive care.


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	No Coverage		None.
	Specialist visit	No Coverage		None.
	Preventive care/screening/ immunization	No charge	No Coverage	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Coverage		None.
	Imaging (CT/PET scans, MRIs)	No Coverage		None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ChemcoBenefits.com	Generic drugs	30-day supply Retail: No Coverage 90-day supply Mail Order: No Coverage		Cost sharing does not apply for preventive Prescriptions.
	Preferred brand drugs	30-day supply Retail: No Coverage 90-day supply Mail Order: No Coverage		
	Non-preferred Brand drugs	30-day supply Retail: No Coverage 90-day supply Mail Order: No Coverage		
	Specialty drugs	30-day supply Retail: No Coverage 90-day supply Mail Order: No Coverage		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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Coverage		None.
	Physician/surgeon fees	No Coverage		
If you need immediate medical attention	Emergency room care	No Coverage		None.
	Emergency medical transportation	No Coverage		None.
	Urgent care	No Coverage		None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Coverage		None.
	Physician/surgeon fees	No Coverage		None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Coverage		None.
	Inpatient services	No Coverage		None.
If you are pregnant	Office visits	No Charge		Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	No Coverage		
	Childbirth/delivery facility services	No Coverage		
If you need help recovering or have other special health needs	Home health care	No Coverage		None.
	Rehabilitation services	No Coverage		None.
	Habilitation services	No Coverage		
	Skilled nursing care	No Coverage		None.
	Durable medical equipment	No Coverage		None.
	Hospice services	No Coverage		None.
If your child needs dental or eye care	Children's eye exam	No Charge	No Coverage	Limit of 1 routine exam per year.
	Children's glasses	No Coverage	No Coverage	None.
	Children's dental check-up	No Coverage	No Coverage	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.)
• Non-preventive care.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• Preventive care.

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. 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: : Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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? 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 844-281-5228
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-281-5228
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 844-281-5228
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-281-5228

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** **N/A**
- **Specialist Coinsurance** **100%**
- **Hospital (facility) Coinsurance** **100%**
- **Other Coinsurance** **100%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic test (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$12,700**

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

- **The plan's overall deductible** **N/A**
- **Specialist Coinsurance** **100%**
- **Hospital (facility) Coinsurance** **100%**
- **Other Coinsurance** **100%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic test *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$5,600**

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

- **The plan's overall deductible** **N/A**
- **Specialist Coinsurance** **100%**
- **Hospital (facility) Coinsurance** **100%**
- **Other Coinsurance** **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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