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.coupehealth.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 1-800-882-5158 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	This plan does not have a deductible.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1-3 Preferred Provider: $6,500/individual or $13,000/family per benefit period. Tier 4 Out of Network Provider: Not Applicable.	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?	Penalties for failure to obtain pre-certification for services, 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.coupehealth.com or call 1-800-822-5158 for a list of network providers.	You pay the least if you use a Tier 1 Preferred Provider. You pay more if you use a Tier 2 or Tier 3 Preferred Provider. You will pay the most if you use a Tier 4 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 Tier 1 Preferred Provider, Tier 2 Preferred Provider or Tier 3 Preferred Provider might use a Tier 4 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
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay the least)	Tier 3 Preferred Provider (You will pay the least)	Tier 4 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	$35 copayment	$70 copayment	$105 copayment	$200 copayment	Telemedicine services via Virtual Primary Care/Teladoc P360: $10 copayment.
	Specialist visit	$75 copayment	$150 copayment	$225 copayment	$350 copayment	None.
	Preventive care/screening/ immunization	$0 copayment	$0 copayment	$0 copayment	$0 copayment	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)	Basic labs: $35 copayment Advanced diagnostic labs: $100 copayment X-ray: $100 copayment	Basic labs: $70 copayment Advanced diagnostic labs: $150 copayment X-ray: $150 copayment	Basic labs: $105 copayment Advanced diagnostic labs: $250 copayment X-ray: $250 copayment	Basic labs: $200 copayment Advanced diagnostic labs: $325 copayment X-ray: $350 copayment	None.
	Imaging (CT/PET scans, MRIs)	$400 copayment	$550 copayment	$1,000 copayment	$1,500 copayment	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay the least)	Tier 3 Preferred Provider (You will pay the least)	Tier 4 Out of Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.primetherapeutics.com.	Generic drugs	Retail: 20% coinsurance ($20 minimum /$50 maximum) Mail order: 20% coinsurance ($50 minimum /$125 maximum)	Tier 1 Preferred Provider benefit applies	Tier 1 Preferred Provider benefit applies	Retail: Not covered Mail order: Not covered	For maintenance medication under 90-Day My Way: 90-day supply at Retail or Mail Order. 30-day supply at Retail. 90-day supply at Mail Order. Copayments and coinsurance does not apply to preventive drugs required by the Affordable Care Act. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Out of Network Provider drugs, you are responsible for 25% of the eligible amount after the coinsurance.
	Preferred drugs	Retail: $20% coinsurance ($60 minimum /$95 maximum) Mail order: 20% coinsurance ($150 minimum /$237.50 maximum)	Tier 1 Preferred Provider benefit applies	Tier 1 Preferred Provider benefit applies	Retail: Not covered Mail order: Not covered	
	Non-preferred drugs	Retail: 30% coinsurance ($75 minimum /$150 maximum) Mail order: 30% coinsurance ($187.50 minimum /$375 maximum)	Tier 1 Preferred Provider benefit applies	Tier 1 Preferred Provider benefit applies	Retail: Not covered Mail order: Not covered	
	Specialty drugs	Retail: $250 copayment	Tier 1 Preferred Provider benefit applies	Tier 1 Preferred Provider benefit applies	Retail: Not covered Mail order: Not covered	Specialty drugs covered up to a 30-day supply only.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay the least)	Tier 3 Preferred Provider (You will pay the least)	Tier 4 Out of Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,700 copayment	$2,500 copayment	$5,000 copayment	$10,000 copayment	Preauthorization may be required.
	Physician/surgeon fees	$0 copayment	$0 copayment	$0 copayment	$0 copayment	
If you need immediate medical attention	Emergency room care	$750 copayment	$750 copayment	$750 copayment	$750 copayment	Non-emergency use of the emergency room is subject to a $500 penalty and does not apply to the deductible or out-of-pocket limit.
	Emergency medical transportation	$750 copayment	$750 copayment	$750 copayment	$750 copayment	None.
	Urgent care	$100 copayment	$100 copayment	$100 copayment	$100 copayment	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$3,600 copayment	$5,000 copayment	$7,500 copayment	$10,000 copayment	Preauthorization may be required.
	Physician/surgeon fees	$0 copayment	$0 copayment	$0 copayment	$0 copayment	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $35 copayment Other outpatient services: $1,700 copayment	Office visits: $70 copayment Other outpatient services: $2,500 copayment	Office visits: $105 copayment Other outpatient services: $5,000 copayment	Office visits: $200 copayment Other outpatient services: $10,000 copayment	Preauthorization is required for Partial and Intensive Outpatient services.
	Inpatient services	$3,600 copayment	$5,000 copayment	$7,500 copayment	$10,000 copayment	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay the least)	Tier 3 Preferred Provider (You will pay the least)	Tier 4 Out of Network Provider (You will pay the most)	
If you are pregnant	Office visits	$35 copayment	$70 copayment	$105 copayment	$200 copayment	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services from a participating provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$0 copayment	$0 copayment	$0 copayment	$0 copayment	
	Childbirth/delivery facility services	$3,600 copayment	$5,000 copayment	$7,500 copayment	$10,000 copayment	
If you need help recovering or have other special health needs	Home health care	$75 copayment	$100 copayment	$170 copayment	$205 copayment	120 visits per benefit period combined with private duty nursing. Preauthorization is required.
	Rehabilitation services	$75 copayment	$100 copayment	$170 copayment	$205 copayment	90 visits combined per benefit period for physical, occupational, pulmonary, cognitive and speech therapies.
	Habilitation services	$75 copayment	$100 copayment	$170 copayment	$205 copayment	
	Skilled nursing care	$3,600 copayment	$5,000 copayment	$7,500 copayment	$10,000 copayment	90 days per benefit period. Preauthorization is required.
	Durable medical equipment	$175 copayment	$250 copayment	$400 copayment	$500 copayment	Limited to items used to serve a medical purpose. Benefits are provided for both purchase and rental (up to the purchase price). Preauthorization is required for all rentals and any purchase over $1,500.
	Hospice services	$395 copayment	$520 copayment	$880 copayment	$1,060 copayment	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay the least)	Tier 3 Preferred Provider (You will pay the least)	Tier 4 Out of Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered	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.)

- Dental care (Adult & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Weight loss programs

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

- Acupuncture (limited to 20 visits per benefit period)
- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 20 visits per benefit period)
- Cosmetic surgery (to correct congenital deformities or conditions resulting from accidental injuries, scars, tumors or diseases)
- Hearing aids (limit 1 new aid per ear per 36-month period, up to $5,000 maximum)
- Infertility treatment (only to diagnose infertility)
- Private-duty nursing (outpatient only)
- Routine foot care (covered only with connection with diagnosis of diabetes)

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 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: 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 1-800-882-5158.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-882-5158.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-882-5158.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-882-5158 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-882-5158.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-882-5158.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-882-5158.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-882-5158.

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 (Tier 1 Preferred Provider) deductible	$0
Specialist copayment	$75
Hospital (facility) copayment	$3,600
Other copayment	$1,700

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$4,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,460**

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

The plan's overall (Tier 1 Preferred Provider) deductible	$0
Specialist copayment	$75
Hospital (facility) copayment	$3,600
Other copayment	$1,700

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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

The plan's overall (Tier 1 Preferred Provider) deductible	$0
Specialist copayment	$75
Hospital (facility) copayment	$3,600
Other copayment	$1,700

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(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	$2,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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