

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Coverage Period:**[Deal.EffectiveDate] to [Deal.EndDate]

**Staff Benefits Management & Administrators: Minimum Essential Coverage (MEC) EliteCare**

**Coverage for:** Eligible Employees and Eligible Dependents | **Plan Type:** Preventive Plus

---



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 1-888-505-7724. 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 1-888-505-7724 to request a copy.

| Important Questions  | Answers   | Why This Matters:   |
|--|---|---|
| <b>What is the overall deductible?</b>                             | \$0   | See the Common Medical Events chart below for your costs for services this plan covers.   |
| <b>Are there services covered before you meet your deductible?</b> | Not Applicable  | You do not need to meet any deductible before the plan pays for services, but see the chart starting on page 2 for the services this plan covers.   |
| <b>Are there other deductibles for specific services?</b>          | Not Applicable  | You do not need to meet any deductible before the plan pays for services, but see the chart starting on page 2 for the services this plan covers.   |
| <b>What is the out-of-pocket limit for this plan?</b>              | \$1,850 individual / \$3,700 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 is reached.  |
| <b>Will you pay less if you use a network provider?</b>            | Not Applicable  | You must use a network provider. There is no coverage for out-of-network services.  |
| <b>Will you pay more if you use an out-of-network provider?</b>    | Yes. Visit <a href="http://www.multiplan.com/sbmaspecificservices">www.multiplan.com/sbmaspecificservices</a> or call 1-800-457-1309 for a list of network providers. | This plan uses a provider network. You will pay 100% of the cost for services if you use an out-of-network provider. 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. |
| <b>Do you need a referral to see a specialist?</b>                 | No  | You can see an in-network specialist you choose without a referral.   |

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Released on April 6, 2016

| <b>Common Medical Event</b>                                   | <b>Services You May Need</b>                     | <b><u>Network Provider</u><br/>(You will pay the least)</b> | <b><u>Out-of-Network Provider</u><br/>(You will pay the most)</b> | <b>Limitations, Exceptions, &amp; Other Important Information</b>   |
|---|--|---|---|---|
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness | \$15 copay/visit  | Not covered   | None.   |
|   | Specialist visit                                 | \$15 copay/visit  | Not covered   | None  |
|   | Preventive care/screening/immunization           | \$0   | Not covered   | With respect to all preventive services provided under the plan, if a recommendation or guideline for a service frequency, method, treatment or setting for the service, the plan will use reasonable medical management techniques to determine coverage limitations. You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for. |
| <b>If you have a test</b>                                     | Diagnostic test (x-ray, blood work)              | \$0 for preventive blood work, otherwise \$50 copay         | Not covered   | None  |
|   | Imaging (CT/PET scans, MRIs)                     | Not covered   | Not covered   | No coverage for advanced imaging.   |
| <b>If you need drugs to treat your illness or condition</b>   | Tier 1   | \$15 copay  | Not covered   | Non-preferred brand name and specialty prescription drugs are excluded. Prescription drugs that are considered preventive are provided free of charge but may or may not be subject to any coverage limitations. Ask your provider if the prescription drugs needed are preventive, then check what your plan will pay for. Coverage is limited to the formulary drug list.   |
|   | Tier 2   | \$30 copay  |   |   |
|   | Tier 3   | \$50 copay  |   |   |
|   | Tier 4   | \$75 copay  |   |   |
|   | Non-preferred brand drugs                        | Not covered   |   |   |
|   | Specialty drugs                                  | Not covered   |   |   |

\* For more information about limitations and exceptions, call 1-888-505-7724

| <b>Common Medical Event</b>  | <b>Services You May Need</b>                   | <b><u>Network Provider</u><br/>(You will pay the least)</b> | <b><u>Out-of-Network Provider</u><br/>(You will pay the most)</b> | <b>Limitations, Exceptions, &amp; Other Important Information</b> |
|--|--|---|---|---|
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | Not covered   | Not covered   | No coverage for facility fee (e.g., ambulatory surgery center).   |
|  | Physician/surgeon fees                         | Not covered   | Not covered   | No coverage for physician or surgeon fees.                        |
| <b>If you need immediate medical attention</b>                                   | Emergency room care                            | Not covered   | Not covered   | No coverage for emergency room care.                              |
|  | Emergency medical transportation               | Not covered   | Not covered   | No coverage for emergency medical transportation.                 |
|  | Urgent care                                    | \$50 copay/visit  | Not covered   | None.   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)             | Not covered   | Not covered   | No coverage for facility fee (e.g., hospital room).               |
|  | Physician/surgeon fees                         | Not covered   | Not covered   | No coverage for surgeon fees.                                     |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                            | Not covered   | Not covered   | No coverage for outpatient services.                              |
|  | Inpatient services                             | Not covered   | Not covered   | No coverage for inpatient services.                               |
|  | Behavioral health services                     | Not covered   | Not covered   | No coverage for behavioral health services                        |
| <b>If you are pregnant</b>   | Office visits                                  | \$0 for preventive services, otherwise \$15 copay/visit     | Not covered   | None  |
|  | Childbirth/delivery professional services      | Not covered   | Not covered   | No coverage for childbirth or delivery professional services.     |
|  | Childbirth/delivery facility services          | Not covered   | Not covered   | No coverage for childbirth or delivery facility services.         |

\* For more information about limitations and exceptions, call 1-888-505-7724

| Common Medical Event  | Services You May Need      | Network Provider<br>(You will pay the least) | Out-of-Network<br>Provider<br>(You will pay the most) | Limitations, Exceptions, &<br>Other Important Information |
|---|----------------------------|--|---|---|
| <b>If you need help recovering or have other special health needs</b> | Home health care           | Not covered                                  | Not covered   | No coverage for home health care.                         |
|   | Rehabilitation services    | Not covered                                  | Not covered   | No coverage for rehabilitation services.                  |
|   | Habilitation services      | Not covered                                  | Not covered   | No coverage for habilitation services.                    |
|   | Skilled nursing care       | Not covered                                  | Not covered   | No coverage for skilled nursing care.                     |
|   | Durable medical equipment  | Not covered                                  | Not covered   | No coverage for durable medical equipment.                |
|   | Hospice services           | Not covered                                  | Not covered   | No coverage for hospice services.                         |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam        | Not covered                                  | Not covered   | No coverage for children's eye exam.                      |
|   | Children's glasses         | Not covered                                  | Not covered   | No coverage for children's glasses.                       |
|   | Children's dental check-up | Not covered                                  | Not covered   | No coverage for children's dental check-up.               |

\*For more information about limitations and exceptions, call 1-888-505-7724



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

\* For more information about limitations and exceptions, call 1-888-505-7724

## 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                           | Dental Care (Adult)   | Private-duty nursing     |
| Bariatric Surgery                     | Hearing Aids          | Routine Eye Care (Adult) |
| Care when traveling outside the US    | Infertility Treatment | Routine Foot Care        |
| Chiropractic Care<br>Cosmetic Surgery | Long-Term Care        | Weight Loss programs     |

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

None

**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: the 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: 1-888-505-7724 or the 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). Additionally, a consumer assistance program may be available in your state to help you file your appeal. A list of states with Consumer Assistance Programs is available at: [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/> or you may contact 1-888-505-7724 for more information.

### 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 the Minimum Value Standards? **No**

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 1-888-505-7724)

(Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-505-7724)

(Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-505-7724)

(Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-505-7724)

————— 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.

| <b>Peg is Having a Baby</b><br>(9 months of in-network pre-natal care and a hospital delivery)   |                 | <b>Managing Joe's type 2 Diabetes</b><br>(a year of routine in-network care of a well-controlled condition)  |                | <b>Mia's Simple Fracture</b><br>(in-network emergency room visit and follow up care)   |                |
|--|-----------------|--|----------------|--|----------------|
| The plan's overall deductible  | \$0             | The plan's overall deductible  | \$0            | The plan's overall deductible  | \$0            |
| Specialist copay   | \$15            | Primary care copay   | \$15           | Emergency Room copay   | N/A            |
| Hospital (facility)  | N/A             | Specialty prescription drugs   | N/A            | X-ray copay  | \$50           |
| Other cost sharing   | Varies          | Other cost sharing   | Varies         | Other cost sharing   | Varies         |
| <b>This EXAMPLE event includes services like:</b><br>Specialist office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br>Diagnostic tests ( <i>ultrasounds and blood work</i> ) |                 | <b>This EXAMPLE event includes services like:</b><br>Primary care physician office visits ( <i>including disease education</i> )<br>Diagnostic tests (blood work)<br>Prescription drugs<br>Durable medical equipment (glucose meter) |                | <b>This EXAMPLE event includes services like:</b><br>Emergency room care (including medical supplies)<br>Diagnostic test (x-ray)<br>Durable medical equipment (crutches)<br>Rehabilitation services (physical therapy) |                |
| <b>Total Example Cost</b>  | <b>\$12,800</b> | <b>Total Example Cost</b>  | <b>\$4,500</b> | <b>Total Example Cost</b>  | <b>\$7,200</b> |
| <b>In this example, Peg would pay:</b>   |                 | <b>In this example, Joe would pay:</b>   |                | <b>In this example, Mia would pay:</b>   |                |
| <i>Cost Sharing</i>  |                 | <i>Cost Sharing</i>  |                | <i>Cost Sharing</i>  |                |
| Deductibles  | \$0             | Deductibles  | \$0            | Deductibles  | \$0            |
| Copayments   | \$190           | Copayments   | \$160          | Copayments   | \$100          |
| Coinsurance  | \$0             | Coinsurance  | \$0            | Coinsurance  | \$0            |
| <i>What isn't covered</i>  |                 | <i>What isn't covered</i>  |                | <i>What isn't covered</i>  |                |
| Limits or exclusions   | \$10,500        | Limits or exclusions   | \$3,600        | Limits or exclusions   | \$6,750        |
| <b>The total Peg would pay is</b>  | <b>\$10,690</b> | <b>The total Joe would pay is</b>  | <b>\$3,760</b> | <b>The total Mia would pay is</b>  | <b>\$6,850</b> |

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

\* For more information about limitations and exceptions, call 1-888-505-7724