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 800.753.8429. 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.cciio.cms.gov or call 800.753.8429 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | Network = Single: $500/ Family: $1,000<br>Non-Network = Single: $6,400/ Family: $12,800 | 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 policy, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes | 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? | Coinsurance Only Maximum:<br>Network = Single: $1,500/ Family: $3,000<br>Non-Network = Single: $17,400/Family: $34,800<br>Maximum Out-of-Pocket:<br>Network = Single: $7,350/Family:$14,700<br>Non-Network = Single: $23,800/ Family: $47,600 | 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 billed charges, health care this plan does not cover, and penalties for failure to obtain pre-authorization for services. | 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. For a list of Network Providers, visit summacare.com or call 800.753.8429. | 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 a non-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 a non-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) | Non- 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 | $10 copay/visit; Deductible does not apply | 40% coinsurance | None |
| | Specialist visit | $20 copay/visit; Deductible does not apply | 40% coinsurance | None |
| | Preventive care/screening/ Immunization | No charge | 40% coinsurance | None |
| If you have a test | Diagnostic test (x-ray, Medical tests | 10% coinsurance | 40% coinsurance | None |
| | Diagnostic Lab | Free standing facility-$10 copay/visit; Institutional-10% coinsurance | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 40% coinsurance | Requires prior authorization |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.summacare.com | Tier 1 (Typically Generic) | Retail: $10 copay/prescription Mail Order: $20 copay/prescription Deductible does not apply | Not Covered | Specialty drugs are considered under Tier 3 and must be filled at AcariaHealth and are limited to a 30 day supply. Retail pharmacies are limited to dispensing 30 day supply of drugs unless the pharmacy is part of the MedImpact Choice 90 program. |
| | Tier 2 (Typically Preferred Brand and Non-Preferred Generic) | Retail: $25 copay/prescription Mail Order: $50 copay/prescription Deductible does not apply | Not Covered | |
| | Tier 3 (Typically Non-Preferred | Retail: $50 | Not Covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non- Network Provider (You will pay the most) | |
| | Brand and Generic) | copay/prescription Mail Order: $100 copay/prescription Deductible does not apply | | |
| | Tier 3 (Typically Preferred Specialty) | Retail: $50 copay/prescription Mail Order: $100 copay/prescription Deductible does not apply | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 40% coinsurance | May require prior authorization |
| | Physician/surgeon fees | 10% coinsurance | 40% coinsurance | None |
| If you need immediate medical attention | Emergency room care | $150 copay/visit, then 100%. Deductible does not apply | | Copay waived if admitted |
| | Non-Emergency use of the Emergency Room | 10% coinsurance | 40% coinsurance | None |
| | Emergency medical transportation | 10% coinsurance | 40% coinsurance | Air ambulance requires prior authorization |
| | Urgent care | $30 copay/visit Deductible does not apply | 40% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 40% coinsurance | Requires prior authorization |
| | Physician/surgeon fees | 10% coinsurance | 40% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Benefits paid based on corresponding medical benefits | | None |
| | Inpatient services | | | Requires prior authorization |
| If you are pregnant | Office visits | No charge | 40% coinsurance | None |
| | Childbirth/delivery professional services | 10% coinsurance | 40% coinsurance | None |
| | Childbirth/delivery facility services | 10% coinsurance | 40% coinsurance | Requires prior authorization |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Non- Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | 40% coinsurance | Limited to 40 visits per benefit period |
| | Rehabilitation services | $10 copay PCP/visit<br>$20 copay Specialist/visit | 40% coinsurance | PT/OT combined limit of 25 visits. Chiropractic limited to 25 visits. Speech therapy limited to 10 visits. |
| | Habilitation services | 10% coinsurance | 40% coinsurance | None |
| | Skilled nursing care | 10% coinsurance | 40% coinsurance | None |
| | Durable medical equipment | 10% coinsurance | 40% coinsurance | Requires prior authorization |
| | Hospice services | 10% coinsurance | 40% coinsurance | None |
| If your child needs dental or eye care | Children's eye exam | Not Covered | Not Covered | Refer to separate vision plan |
| | Children's glasses | Not Covered | Not Covered | Refer to separate vision plan |
| | Children's dental check-up | Not Covered | Not Covered | Refer to separate dental plan |

## 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.
- Routine Foot Care
- Weight Loss program

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

- Abortion
- Chiropractic Care
- Private Duty Nursing
- 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: state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.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. For more information on your rights to continue coverage, contact the plan at 1-800-753-8429. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov.

**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

* For more information about limitations and exceptions, see the plan or policy document at www.summacare.com

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: SummaCare at 800.753.8429 or contact us via our website at summacare.com. You may also contact the 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

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? 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 1-800-753-8429.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-753-8429.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-753-8429.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-753-8429.

*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 network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist *[cost sharing]* | $20 |
| Hospital (facility) *[cost sharing]* | 10% |
| Other *[cost sharing]* | 10% |

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 | $500 |
| Copayments | $200 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $1,060 |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist *[cost sharing]* | $20 |
| Hospital (facility) *[cost sharing]* | 10% |
| Other *[cost sharing]* | 10% |

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 | $500 |
| Copayments | $300 |
| Coinsurance | $30 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| The total Joe would pay is | $850 |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| Specialist *[cost sharing]* | $20 |
| Hospital (facility) *[cost sharing]* | 10% |
| Other *[cost sharing]* | 10% |

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 | $500 |
| Copayments | $300 |
| Coinsurance | $40 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $840 |

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