

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 1-800-999-5382. 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.healthcare.gov or call 1-800-999- 5382 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Not Applicable; there are no deductibles under this Plan	You do not have to meet a deductible for services covered under this Plan.
Are there services covered before you meet your deductible ?	Not Applicable; there are no deductibles under this Plan.	You do not have to meet a deductible for services covered under this Plan.
Are there other deductibles for specific services?	Not Applicable; there are no deductibles under this Plan.	You do not have to meet a deductible for services covered under this Plan.
What is the out-of-pocket limit for this plan ?	There are no out of pocket limits under this Plan.	Out-of-Pocket expenses under this Plan include premium and preventive services not covered under this Plan. This includes all services other than in-network preventative services.
What is not included in the out-of-pocket limit ?	Preventative services this plan does not cover.	This includes all services other than in-network preventative services.
Will you pay less if you use a network provider ?	Yes.	If you use a network doctor or other health care provider, this Plan will pay 100% of the covered preventative services.
Do you need a referral to see a specialist ?	No.	You do not need a referral to see a specialist. Please note that this Plan will only pay for 100% of covered in-network preventative services.

 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	Not covered	Not covered	No coverage for primary care visits to treat an injury or illness
	Specialist visit	Not covered	Not covered	No coverage for a specialist visit except for covered in-network preventive services.
	Preventive care/screening/immunization	\$0	Not covered	Out of Network preventive services are not covered.
If you have a test	Diagnostic test (x-ray, blood work)	\$0	Not covered	Coverage is only provided for covered in-network preventive services.
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	No coverage for imaging.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mypalico.com .	Generic drugs (Tier 1)	Not covered	Not covered	Coverage is only provided for covered in-network preventive generic drugs.
	Preferred brand drugs (Tier 2)	Not covered	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Not covered	
	Specialty drugs (Tier 4)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	No coverage for facility fees
	Physician/surgeon fees	Not covered	Not covered	No coverage for physician/surgeon fees
If you need immediate medical attention	Emergency room care	Not covered	Not covered	No coverage for emergency room services. No coverage for emergency medical transportation. No coverage for urgent care.
	Emergency medical transportation	Not covered	Not covered	
	Urgent care	Not covered	Not covered	

If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	No coverage for facility fees
	Physician/surgeon fees	Not covered	Not covered	No coverage for physician fees.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	No coverage for mental, behavioral health, or substance abuse outpatient services and/ or inpatient services
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	Not covered	Not covered	Coverage is only provided for covered in-network preventive services. No coverage for Childbirth/delivery professional services. No coverage for Childbirth/delivery facility services.
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	No coverage for home health care
	Rehabilitation services	Not covered	Not covered	No coverage for rehabilitation services and or habilitation services
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Not covered	Not covered	No coverage for skilled nursing
	Durable medical equipment	Not covered_	Not covered	No coverage for durable medical equipment
	Hospice services	Not covered	Not covered	No coverage for hospice care
If your child needs dental or eye care	Children's eye exam	No charge for child screening.	Not covered	Coverage is only provided for covered in-network preventive services.
	Children's glasses	Not covered	Not covered	No coverage for glasses
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up

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 .)			
• Cosmetic surgery • Dental care (Adult) • Infertility treatment • Any service for an Injury or illness.	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine foot care • Any service not covered under the preventive care benefit. • Charges incurred in connection with routine vision exams (except as required under the wellness benefit)	

Excluded Services & Other Covered Services:

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

- | | | |
|--|--|--|
| • Immunizations for Adults and Children | • Colorectal cancer screening (including CT colonography*, fecal occult blood testing, screening sigmoidoscopy, and screening colonoscopy) | • Newborn screening for hearing, thyroid disease, phenylketonuria and sickle cell anemia and standard metabolic screening panel for inherited enzyme deficiency diseases |
| • Cholesterol and lipid disorders | • Major depressive disorders screening | • Counseling for fluoride use |
| • Genetic screening and evaluation for the BCRA breast cancer gene | | |
| • Cervical cancer screening including Pap smears | | |

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 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.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 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: 1-800-999-5382. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/prgrams/consumer/capgrants/index.html>".

Does this plan provide Minimum Essential Coverage? This plan or policy does provide minimum essential coverage.

[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? The health coverage does not meet the minimum value standard for the benefits it provides.

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 1-800-999-5382.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-999-5382.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-999-5382.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-999-5382.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.02** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	n/a
■ Other coinsurance	n/a

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	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$12,663
The total Peg would pay is	\$12,663

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	n/a
■ Other coinsurance	n/a

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	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$5,450
The total Joe would pay is	\$5,450

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	n/a
■ Other coinsurance	n/a

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	\$2,800
The total Mia would pay is	\$2,800

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact us.

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.