



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, contact Personify Health at 833-549-2867. 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 833-549-2867 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible ?	Network <i>Per Calendar Year</i> \$2,000/Self-only Family coverage \$4,000/Family	Out-of-Network <i>Per Calendar Year</i> \$4,000/Self-only Family coverage \$8,000/Family	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. Network preventive care services .		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 ?	Network <i>Per Calendar Year</i> \$6,000/Self-only Family coverage \$6,000/Individual \$12,000/Family Unit	Out-of-Network <i>Per Calendar Year</i> \$12,000/Self-only Family coverage \$12,000/Individual \$24,000/Family Unit	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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit ?	Premiums , balance billed charges, and health care this plan doesn't cover are not included.	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. Visit app.personifyhealth.com or call 833-549-2867 for a list of network providers .	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 an 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 network provider might use an 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
		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	20% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/immunization	No charge Deductible waived	Not covered	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)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.cerpassrx.com/members-page/	Generic drugs	Retail \$10/prescription Mail order \$20/prescription	Not covered	Retail: Limited to a 30-day supply. An additional \$10 copay applies when using a Walgreens pharmacy. Pharmacy option for 90-day supply is available at CVS pharmacies only.
	Preferred brand drugs	Retail \$25/prescription Mail order \$50/prescription	Not covered	Mail order: 90-day supply for maintenance drugs. If you or your provider choose a brand-name medication when a generic version is available, you will have to pay the brand cost-sharing and the difference in cost when you fill this medication.
	Non-preferred brand drugs	Retail \$40/prescription Mail order \$80/prescription	Not covered	Prior authorization from CerpassRx required for all prescriptions over \$1,000. Call 888-902-5533.
	Specialty drugs	20% coinsurance (Maximum of \$125)	Not covered	Your plan will require you to obtain specialty medications through a CerpassRx specialty pharmacy or you will owe the full cost of the drug when you fill this medication. Specialty medication is limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	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 need immediate medical attention	Emergency room care	\$500/visit + 30% coinsurance		Copay waived if admitted.
	Emergency medical transportation	20% coinsurance		None
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Precertification may be required for facility services. If you don't get precertification, benefits could be reduced.
	Inpatient services	20% coinsurance	50% coinsurance	Precertification is required. If you don't get precertification, benefits could be reduced.
If you are pregnant	Office visits	No charge Deductible waived	Not covered	Cost-sharing does not apply to certain preventive services . Depending on the type of services, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Precertification is only required for stays exceeding 48 hours after delivery (or 96 hours after C-section). If you don't get precertification when required, benefits could be reduced

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 need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Limited to 100 visits per Calendar Year combined with Outpatient Private Duty Nursing. Precertification is required. If you don't get precertification, benefits could be reduced.
	Rehabilitation services	20% coinsurance	50% coinsurance	None
	Habilitation services	20% coinsurance	50% coinsurance	None
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 100 days per Calendar Year. Precertification is required. If you don't get precertification, benefits could be reduced.
	Durable medical equipment	20% coinsurance	50% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
	Hospice services	20% coinsurance	Not covered	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced.
If your child needs dental or eye care	Children's eye exam	Not covered		Children's eye exams are covered when provided by a pediatrician as part of a routine well-child visit. See vision plan for other coverage.
	Children's glasses	Not covered		See vision plan for other coverage.
	Children's dental check-up	Not covered		See dental plan for other coverage.

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](#).)

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|-----------------------|---|----------------------------|
| • Bariatric Surgery | • Hearing Aids | • Private Duty Nursing |
| • Cosmetic Surgery | • Long Term Care | • Routine Eye Care (Adult) |
| • Dental Care (Adult) | • Non-emergency care when traveling outside the U.S | • Routine Foot Care |
| | | • Weight Loss Programs |

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

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|--|---|---|
| • Acupuncture (Limited to 40 visits per Calendar Year) | • Infertility Treatment (Services to diagnose infertility only) | • Private Duty Nursing (Network Outpatient only, 100 visits per Calendar Year combined with Home Health Care) |
| • Chiropractic Care (Limited to 40 visits per Calendar Year) | | |

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: Tri-Ad at (760) 705-3080 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: Personify Health at 833-549-2867 or 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 833-549-2867.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-549-2867.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 833-549-2867.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 833-549-2867.

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	\$2,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other (Tests) coinsurance	20%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$2,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,170

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$2,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other (Brand drugs) copayment	\$25

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,200
Copayments	\$900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,120

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,000
■ Specialist coinsurance	20%
■ Hospital(ER) copay+coinsurance	\$500+30%
■ Other (Physical Therapy) coinsurance	20%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$500
Coinsurance	\$70
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,570

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