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 1-407-333-3278. 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 1-407-333-3278 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$6,350 individual / $12,700 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. The following services: • Preventive care • Primary Care and Specialist visits • Prescription Drugs (only Tier 1) • Urgent care	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?	Yes. $250 Prescription Drug deductible applies to Tiers 2-4.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$6,350 individual / $12,700 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 has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties 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?	No.	This plan treats most providers the same in determining payment for the same services. Non-contracted providers may balance-bill for excess charges.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Preferred PCP: $10 copay; deductible does not apply All others: $40 copay; deductible does not apply	Copay applies per visit no matter what services are rendered. Visit www.myemployersolutions.com for a list of preferred providers.
	Specialist visit	$65 copay; deductible does not apply	Copay applies per visit no matter what services are rendered. Chiropractic care is limited to 26 visits per plan year. The chiropractic care plan year maximum also applies to the outpatient therapy plan year maximum.
	Preventive care/screening/ immunization	No charge; deductible does not apply	Limited to one exam per plan year. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Preauthorization is required for outpatient services. If you don't receive preauthorization, benefits will be reduced by $400 per occurrence.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com or call 1-800-424-5876.	Generic drugs (Tier 1)	Retail: $10 copay/prescription Mail Order: $25 copay/prescription	Deductible waived for Tier 1. $250 Prescription Drug Deductible applies to Tier 2-4. Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	Retail: $50 copay/prescription Mail Order: $125 copay/prescription	
	Non-preferred brand drugs (Tier 3)	Retail: $80 copay/prescription Mail Order: $200 copay/prescription	
	Specialty drugs (Tier 4)	20% coinsurance up to a maximum $500 copay/prescription	Specialty drugs limited to a 30-day supply

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Preauthorization is required. If you don't receive preauthorization, benefits will be reduced by $400 per occurrence.
	Physician/surgeon fees	0% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	None
	Urgent care	$100 copay; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Preauthorization is required. If you don't receive preauthorization, benefits will be reduced by $400 per occurrence.
	Physician/surgeon fees	0% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay; deductible does not apply	None
	Inpatient services	0% coinsurance	Preauthorization is required. If you don't receive preauthorization, benefits will be reduced by $400 per occurrence.
If you are pregnant	Office visits	$65 copay; deductible does not apply	Copay applies to the initial visit only. Cost sharing does not apply to certain preventive services. Depending on the type of services, copays, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	0% coinsurance	None
	Rehabilitation services	0% coinsurance	Preauthorization is required. If you don't receive preauthorization, benefits will be reduced by $400 per occurrence. Occupational, speech, physical, ABA and massage therapies are limited to 35 visits per plan year (rehabilitation and habilitation combined). Chiropractic manipulations are also included in the 35 visit per plan year maximum.
	Habilitation services	0% coinsurance	None
	Skilled nursing care	0% coinsurance	Preauthorization is required. If you don't receive preauthorization, benefits will be reduced by $400 per occurrence. Limited to 60 days per plan year.
	Durable medical equipment	0% coinsurance	None
	Hospice services	0% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.
	Children's glasses	Not Covered	None
	Children's dental check-up	Not Covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.

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
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- 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.)

- Chiropractic Care (Limited to 26 visits per Plan year and applies to 35 visit maximum for all therapies combined)

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 the plan is 1-407-333-3278. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA 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 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 the plan at 1-407-333-3278. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. A list of consumer assistance program offices in each state is available at https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 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: **1-877-236-0844**
Spanish (Español): Para obtener asistencia en Español, llame al
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
Chinese (中文): 如果需要中文的帮助，请拨打这个号码
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

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	$6350
Specialist copayment	$65
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,350
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,410**

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

The plan's overall deductible	$6350
Specialist copayment	$65
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,112
Copayments	$1,410
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,577**

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

The plan's overall deductible	$6350
Specialist copayment	$65
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,632
Copayments	$195
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,827**

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.