



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, go to <https://hconline.healthcomp.com> or by calling 1-800-843-3831. 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/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-866-444-EBSA (3272) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network providers</a> : \$1,500 Individual / \$3,000 Family <a href="#">Out-of-Network providers</a> : \$1,500 Individual / \$3,000 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<a href="#">Deductible</a> does not apply to: <ul style="list-style-type: none"> <li>· ACA <a href="#">Preventive Care</a></li> <li>· Prescription drugs</li> <li>· Services with a <a href="#">copayment</a></li> </ul>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at: <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network providers</a> : \$3,500 Individual / \$7,000 Family <a href="#">Out-of-Network providers</a> : \$7,000 Individual / \$14,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges; charges in excess of UCR (Usual, Customary & Reasonable); any noncompliance penalties; and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://hconline.healthcomp.com">https://hconline.healthcomp.com</a> or call 1-800-843-3831 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">Co-Pay</a> /Visit	50% <a href="#">Coinsurance deductible</a> applies	---none---
	<a href="#">Specialist</a> visit	\$60 <a href="#">Co-Pay</a> /Visit	50% <a href="#">Coinsurance deductible</a> applies	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	You may have to pay for services that are not <a href="#">preventive</a> . Ask your provider if services needed are <a href="#">preventive</a> , then check what your <a href="#">plan</a> will pay.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Office: \$30/\$60 <a href="#">Co-Pay</a> /visit Facility: 30% <a href="#">Coinsurance deductible</a> applies	50% <a href="#">Coinsurance deductible</a> applies	Lab Card & LabCorp: No Charge
	Imaging (CT/PET scans, MRIs)	30% <a href="#">Coinsurance deductible</a> applies	50% <a href="#">Coinsurance deductible</a> applies	US Imaging: No Charge Non-compliance penalty of \$250 per occurrence.
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="https://hconline.healthcomp.com">https://hconline.healthcomp.com</a>	Generic drugs	\$5.00 <a href="#">Co-Pay</a> Retail \$12.50 <a href="#">Co-Pay</a> Mail Order		Covers up to a 30-day supply (retail pharmacy); 90-day supply (mail order pharmacy).
	Preferred brand drugs	\$50.00 <a href="#">Co-Pay</a> Retail \$125.00 <a href="#">Co-Pay</a> Mail Order		Retail Pharmacy Option (30 day Supply) & Mail Order Option (90 day Supply) Subject to the Medical Out-of-Pocket Maximum
	Non-preferred brand drugs	\$75.00 <a href="#">Co-Pay</a> Retail \$187.50 <a href="#">Co-Pay</a> Mail Order		<a href="#">Specialty drugs</a> are only available in a 30-day supply.
	<a href="#">Specialty drugs</a>	\$100.00 <a href="#">Co-Pay</a> Retail \$250.00 <a href="#">Co-Pay</a> Mail Order		Certain medications are considered preventive care under ACA and are payable at no cost-share to member.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">Coinsurance deductible</a> applies		Non-compliance penalty of \$250 per occurrence.
	Physician/surgeon fees	30% <a href="#">Coinsurance deductible</a> applies	50% <a href="#">Coinsurance deductible</a> applies	

[\* For more information about limitations and exceptions, see the plan or policy document at <https://hconline.healthcomp.com>

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 immediate medical attention	<a href="#">Emergency room care</a>	\$200 Co-Pay/visit; 30% Coinsurance; deductible waived		Co-Pay waived if Admitted Directly to Hospital from Emergency Room.
	<a href="#">Emergency medical transportation</a>	\$200 Co-Pay/visit; 30% Coinsurance; deductible waived		---none---
	<a href="#">Urgent care</a>	\$100 Co-Pay/visit; 0% Coinsurance; deductible waived		Co-Pay applies to visit only. All other services deductible then 30% coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance deductible applies		Non-compliance penalty of \$250 per occurrence.
	Physician/surgeon fees	30% Coinsurance deductible applies	50% Coinsurance deductible applies	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 Co-Pay/office. 30% Coinsurance. deductible waived	50% Coinsurance deductible applies	---none---
	Inpatient services	30% Coinsurance deductible applies		. Non-compliance penalty of \$250 per occurrence.
If you are pregnant	Office visits	\$30 Co-Pay/Initial visit; deductible waived	50% Coinsurance deductible applies	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% Coinsurance deductible applies	50% Coinsurance deductible applies	
	Childbirth/delivery facility services	30% Coinsurance deductible applies		Non-compliance penalty of \$250 per occurrence.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% Coinsurance deductible applies	50% Coinsurance deductible applies	Calendar Year Maximum 60 visits.
	<a href="#">Rehabilitation services</a>	30% Coinsurance deductible applies	50% Coinsurance deductible applies	Calendar Year Maximum 30 visits per therapy; applies to Physical, Occupational and Speech Therapy. Inpatient Rehab limited to 30 days per calendar year.
	<a href="#">Habilitation services</a>	30% Coinsurance deductible applies	50% Coinsurance deductible applies	
	<a href="#">Skilled nursing care</a>	30% Coinsurance deductible applies	50% Coinsurance deductible applies	Calendar Year Maximum 60 days. Non-compliance penalty of \$250 per occurrence.

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)	
	<a href="#">Durable medical equipment</a>	30% Coinsurance deductible applies	50% Coinsurance deductible applies	Non-compliance penalty of \$250 per occurrence.
	<a href="#">Hospice services</a>	30% Coinsurance deductible applies	50% Coinsurance deductible applies	---none---
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	---none---
	Children's glasses	Not Covered	Not Covered	---none---
	Children's dental check-up	No Charge	Not Covered	See Plan Document for complete Dental benefits

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids Bone-anchored</li> <li>• Long-Term Care</li> <li>• Non-emergency Care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> </ul>

**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: your state insurance department, the U.S. 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) or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or [www.cciio.cms.gov](http://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](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: the Plan at **1-800-843-3831** or your state insurance department or the U.S. 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).

**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 1-800-843-3831.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-843-3831.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-843-3831.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-843-3831.]

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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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](#) \$1,500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**This EXAMPLE event includes services like:**

Primary office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	<b>\$1,500</b>
Copayments	\$0
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,260</b>

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,130
Copayments	\$680
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,830</b>

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$720
Copayments	\$520
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,640</b>



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Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network providers</a> : \$3,500 Individual / \$7,000 Family <a href="#">Out-of-Network providers</a> : \$3,500 Individual / \$7,000 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<a href="#">Deductible</a> does not apply to: <ul style="list-style-type: none"> <li>· ACA <a href="#">Preventive Care</a></li> <li>· Prescription drugs</li> <li>· Services with a <a href="#">copayment</a></li> </ul>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at: <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network providers</a> : \$3,500 Individual / \$7,000 Family <a href="#">Out-of-Network providers</a> : \$7,000 Individual / \$14,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges; charges in excess of UCR (Usual, Customary & Reasonable); any noncompliance penalties; and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>
Will you pay less if you use a <a href="#">network provider</a> ?	<a href="https://hconline.healthcomp.com">https://hconline.healthcomp.com</a> or call 1-800-843-3831 for a list of network providers.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	0% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	30% <a href="#">Coinsurance deductible</a> applies	---none---
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	30% <a href="#">Coinsurance deductible</a> applies	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	You may have to pay for services that are not <a href="#">preventive</a> . Ask your provider if services needed are <a href="#">preventive</a> , then check what your <a href="#">plan</a> will pay.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	30% <a href="#">Coinsurance deductible</a> applies	Lab Card & LabCorp: 0% <a href="#">Coinsurance deductible</a> applies
	Imaging (CT/PET scans, MRIs)	0% <a href="#">Coinsurance deductible</a> applies	30% <a href="#">Coinsurance deductible</a> applies	US Imaging: No Charge Non-compliance penalty of \$250 per occurrence.
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="https://hconline.healthcomp.com">https://hconline.healthcomp.com</a>	Generic drugs	<b>Network Retail:</b> <a href="#">deductible</a> then 0% <a href="#">coinsurance</a> <b>Network Mail Order:</b> <a href="#">deductible</a> then 0% <a href="#">coinsurance</a>		Covers up to a 30-day supply (retail pharmacy); 90-day supply (mail order pharmacy). Retail Pharmacy Option (30 day Supply) & Mail Order Option (90 day Supply) Subject to the Medical Out-of-Pocket Maximum <a href="#">Specialty drugs</a> are only available in a 30-day supply. Certain medications are considered preventive care under ACA and are payable at no cost-share to member.
	Preferred brand drugs			
	Non-preferred brand drugs			
	<a href="#">Specialty drugs</a>	<b>Network Retail:</b> <a href="#">deductible</a> then 0% <a href="#">coinsurance</a>		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies		Non-compliance penalty of \$250 per occurrence.
	Physician/surgeon fees	0% <a href="#">coinsurance</a> ; <a href="#">deductible</a> applies	30% <a href="#">Coinsurance deductible</a> applies	

[\* For more information about limitations and exceptions, see the plan or policy document at <https://hconline.healthcomp.com>



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 immediate medical attention	<a href="#">Emergency room care</a>	0% coinsurance; deductible applies		---none---
	<a href="#">Emergency medical transportation</a>	0% coinsurance; deductible applies		---none---
	<a href="#">Urgent care</a>	0% coinsurance; deductible applies		All other services deductible then 30% coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance; deductible applies		Non-compliance penalty of \$250 per occurrence.
	Physician/surgeon fees	0% coinsurance; deductible applies	30% Coinsurance deductible applies	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance; deductible applies	30% Coinsurance deductible applies	---none---
	Inpatient services	0% coinsurance; deductible applies		. Non-compliance penalty of \$250 per occurrence.
If you are pregnant	Office visits	0% coinsurance; deductible applies	30% Coinsurance deductible applies	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance; deductible applies	30% Coinsurance deductible applies	
	Childbirth/delivery facility services	0% coinsurance; deductible applies		Non-compliance penalty of \$250 per occurrence.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% coinsurance; deductible applies	30% Coinsurance deductible applies	Calendar Year Maximum 60 visits.
	<a href="#">Rehabilitation services</a>	0% coinsurance; deductible applies	30% Coinsurance deductible applies	Calendar Year Maximum 30 visits per therapy; applies to Physical, Occupational and Speech Therapy. Inpatient Rehab limited to 30 days per calendar year. Non-compliance penalty of \$250 per occurrence.
	<a href="#">Habilitation services</a>	0% coinsurance; deductible applies	30% Coinsurance deductible applies	
	<a href="#">Skilled nursing care</a>	0% coinsurance; deductible applies	30% Coinsurance deductible applies	Calendar Year Maximum 60 days. Non-compliance penalty of \$250 per occurrence.
	<a href="#">Durable medical equipment</a>	0% coinsurance; deductible applies	30% Coinsurance deductible applies	Non-compliance penalty of \$250 per occurrence.
	<a href="#">Hospice services</a>	0% coinsurance; deductible applies	30% Coinsurance deductible applies	---none---

[\* For more information about limitations and exceptions, see the plan or policy document at <https://honline.healthcomp.com>

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)	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered	---none---
	Children's glasses	Not Covered	Not Covered	---none---
	Children's dental check-up	No Charge	Not Covered	See Plan Document for complete Dental benefits

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic Surgery</li><li>• Dental Care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing Aids Bone-anchored</li><li>• Long-Term Care</li><li>• Non-emergency Care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Bariatric Surgery</li></ul>	<ul style="list-style-type: none"><li>• Chiropractic Care</li></ul>	<ul style="list-style-type: none"><li>• Infertility Treatment</li></ul>

**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: your state insurance department, the U.S. 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) or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or [www.cciio.cms.gov](http://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](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: the Plan at **1-800-843-3831** or your state insurance department or the U.S. 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).

### 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 1-800-843-3831.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-843-3831.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-843-3831.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-843-3831.]

—————*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](#) \$3,500
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

**This EXAMPLE event includes services like:**

Primary office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	<b>\$3,500</b>
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,560</b>

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

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist coinsurance](#) 0%
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,320
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,320</b>

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

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist coinsurance](#) 0%
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>