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 benefits4nemours.com or call (844) 460-2817. 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 Care Coordinators at (844) 460-2817 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: Individual $1,200 / Family $2,400. Out–of–network: Individual $2,400 / Family $4,800	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 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. For participating providers: Preventive care, routine eye exam, urgent care (all providers), emergency room care (including emergency services for non-participating providers), emergency medical transportation (all providers), rehabilitation services, habilitation services, and office visit charges are covered before you meet your deductible,	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?	In-network: Individual $4,000 / Family $8,000. Out–of–network: Individual $8,000 / Family $16,000	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 & 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?	Yes. See benefits4nemours.com or call: (844) 460-2817 for a list of in-network providers. See www.express-scripts.com or call 1-844-394-2932 for a list of in-network pharmacies	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	$40 copay/visit (office visit)/ 30% coinsurance (all other services)	50% coinsurance	Copay applies to the physician office visit only. Includes telemedicine.
	Specialist visit	$50 copay/visit (office visit)/ 30% coinsurance (all other services)	50% coinsurance	
	Preventive care / screening / immunization	No charge	50% coinsurance	Preventive coverage as identified in Preventive Health Guidelines and ACA requirements. 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)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about	Generic drugs	Retail $10 copay Mail order $25 copay	Not covered	None
	Preferred brand drugs	20% coinsurance Retail Min. $30, Max $60 Mail order Min. $75, Max	Not covered	None

[* For more information about limitations and exceptions, see the plan or policy document]

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)	
prescription drug coverage is available at www.express-scripts.com		$150		
	Non-preferred brand drugs	40% coinsurance Retail Min. $60, Max $120 Mail order Min. $150, Max $300	Not covered	None
	Specialty drugs	20% coinsurance Retail Min. $100, Max $200	Not covered	Mostly injectable drugs administered in the physician's office. Manufacturer assistance for the drugs on the SaveOnSP list will not be used to satisfy the deductible and out-of-pocket maximum
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Preauthorization required. Coinsurance for certain procedures may vary if using a Carrum Centers of Excellence provider
If you need immediate medical attention	Emergency room care	$250 copay/visit; (emergency services and non-emergency services); deductible does not apply	$250 copay/visit; (emergency services); deductible does not apply	Non-participating providers paid at the participating provider level of benefits for emergency services. Copay is waived if admitted to the hospital.
	Emergency medical transportation	$50 copay/trip; deductible does not apply	$50 copay/trip; deductible does not apply	None
	Urgent care	$50 copay/visit; deductible does not apply	$50 copay/visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Unauthorized care will be denied
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Unauthorized care will be denied

[* For more information about limitations and exceptions, see the plan or policy document]

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $40 copay/visit; deductible does not apply Other outpatient: 30% coinsurance	Office Visit: 50% coinsurance Other outpatient: 50% coinsurance	Unauthorized care will be denied
	Inpatient services	30% coinsurance	50% coinsurance	Unauthorized care will be denied
Infertility	Infertility Treatment	30% coinsurance	Not covered	2 Smart Cycles per lifetime. Fertility treatments are administered through Progyny. Please call Progyny at **1-844-930-3289** to activate benefit.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Preauthorization required for inpatient hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (c-section).Cost sharing does not apply to preventive services from a participating provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	100 visits/calendar year. Unauthorized care will be denied.
	Rehabilitation services	$50 copay/visit; deductible does not apply	50% coinsurance	Physical, speech/hearing & occupational therapy limited to 50 visits per each type of therapy per year.
	Habilitation services	$50 copay/visit; deductible does not apply	50% coinsurance	Limited to 50 visits per year through age 19.
	Skilled nursing care	30% coinsurance	50% coinsurance	120 days/confinement. Unauthorized care will be denied.
	Durable medical equipment	30% coinsurance	50% coinsurance	Preauthorization required for rentals or purchase over $1,500.

[* For more information about limitations and exceptions, see the plan or policy document]

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)	
	Hospice services	30% coinsurance	50% coinsurance	Bereavement counseling is covered. Preauthorization required.
If your child needs dental or eye care	Children's eye exam	No charge for preventive visit	50% coinsurance	1 routine eye exam/12 months
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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 & Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs – Except for required preventive services

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

- Acupuncture – 10 visits/calendar year
- Bariatric Surgery
- Chiropractic Care – 30 visits/calendar year
- Hearing Aids – 1 hearing aid per ear/36 months for children up to age 20
- Routine Eye Care (1 routine exam per 12 months)
- Private-Duty Nursing – 30-8-hour shifts/calendar year
- Infertility treatment

[* For more information about limitations and exceptions, see the plan or policy document]

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 (866) 444-3272 or www.dol.gov/ebsa/healthreform or Care Coordinators at (844) 460-2817. 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: The U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform or Care Coordinators at (844) 460-2817.

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): Paraobtener asistencia en Español, llame al 1-800-378-1179.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.
Chinese (中文):如果需要中文的帮助，请拨打这个号码1-800-378-1179.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'1-800-378-1179.

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

[* For more information about limitations and exceptions, see the plan or policy document]

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	**$1,200**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

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	$1,200
Copayments	$10
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,070**

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

The plan's overall deductible	**$1,200**
Specialist copayment	**$50**
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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$1,200
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	**$1,200**
Specialist copayment	**$50**
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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$800
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

Note: The member paid amount is subject to out-of-pocket limit.

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