




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 | 50% coinsurance | Copay applies to the physician office visit only. Includes telemedicine. You pay a \$35 copay (deductible does not apply) if you receive consultation services through Teladoc (available for ages 18 and older) or a \$15 copay for children on the Nemours App. |
| | Specialist visit | \$50 copay /visit | 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 | Generic drugs | Retail \$10 copay Mail order \$25 copay | 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) | |
| treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com | Preferred brand drugs | 20% coinsurance Retail Min. \$30, Max \$60 Mail order Min. \$75, Max \$150 | Not covered | None |
| | 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 |

| 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) | |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | Unauthorized care will be denied |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$40 copay/visit | 50% coinsurance | 8 mental health coaching or therapy sessions for you, your family, and dependents (per person per year), delivered through Lyra Health, at no cost to you. Additional sessions are available at the outpatient services cost share if you are enrolled. Teladoc services are available at \$40 copay/visit. 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. |

| 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) | |
| | 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. |
| | 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

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): Para obtener 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, kwijigo holne'1-800-378-1179.

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 | \$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 |
| <i>What isn't covered</i> | |
| 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 |
| <i>What isn't covered</i> | |
| 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 |
| <i>What isn't covered</i> | |
| 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.