



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 844-682-4031. 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/healthreform](http://www.dol.gov/ebsa/healthreform) or call 844-682-4031 to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	<p><a href="#">Network providers:</a>  \$3,000/individual, \$6,000/family</p> <p><a href="#">Out-of-network provider:</a>  \$5,000/individual, \$10,000/family</p>	<p>Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. The <a href="#">deductible</a> is <b>Embedded</b>. 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>.</p> <p><b>Deductible year runs 01/01 – 12/31</b></p>
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This plan 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 plan covers certain <a href="#">preventive care</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive</a> services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<a href="#">Are there other deductibles for specific services?</a>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<a href="#">What is the out-of-pocket limit for this plan?</a>	<p><a href="#">Network providers:</a>  \$7,000/individual, \$14,000/family</p> <p><a href="#">Out-of-network provider:</a>  \$10,000/individual, \$20,000/family</p>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. The <a href="#">out-of-pocket limit</a> is <b>Embedded</b> . 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.
<a href="#">What is not included in the out-of-pocket limit?</a>	Premiums, <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a network provider?</a>	Yes. See <a href="http://www.CMUBenefits.com">www.CMUBenefits.com</a> or call 844-682-4031 for a list of <a href="#">network providers</a> .	This plan uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ).
<a href="#">Do you need a referral to see a 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)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copayment</u>	50% <u>coinsurance</u>	<u>Deductible</u> does not apply to <u>copayment</u> .
	<u>Specialist</u> visit	\$30 <u>copayment</u>	50% <u>coinsurance</u>	<u>Deductible</u> does not apply to <u>copayment</u> .
	<u>Preventive care/screening/immunization</u>	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Labs in a clinic or independent lab setting are covered at no charge.
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None.
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.CMUBenefits.com">www.CMUBenefits.com</a>	Generic drugs	30-day supply Retail: \$10 <u>copayment/Prescription</u> 90-day supply Mail Order: \$20 <u>copayment/Prescription</u>	<u>Cost sharing</u> does not apply for <u>preventive Prescriptions</u> . <u>Deductible</u> does not apply to <u>copayment</u> . Retail & Mail Order available up to a 90-day supply.	
	Preferred brand drugs	30-day supply Retail: \$45 <u>copayment/Prescription</u> 90-day supply Mail Order: \$90 <u>copayment/Prescription</u>		
	Non-preferred Brand drugs	30-day supply Retail: \$75 <u>copayment/Prescription</u> 90-day supply Mail Order: \$150 <u>copayment/Prescription</u>		
	<u>Specialty drugs</u>	30-day supply Retail: 25% <u>coinsurance/Prescription</u> 90-day supply Mail Order: Not Covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	May require <u>preauthorization</u> .
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	True emergency covered at in-network level.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	True emergency covered at in-network level.
	<u>Urgent care</u>	\$50 <u>copayment</u>	50% <u>coinsurance</u>	<u>Deductible</u> does not apply to <u>copayment</u> .

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 have a hospital stay	Facility fee (e.g., hospital room)	\$50 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required. <a href="#">Deductible</a> does not apply to <a href="#">copayment</a> .
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply to <a href="#">copayment</a> .
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
If you are pregnant	Office visits	No charge	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive</a> services.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
	Childbirth/delivery facility services	\$50 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC. <a href="#">Deductible</a> does not apply to <a href="#">copayment</a> .
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required. 100 days per year maximum combined with Private Duty Nursing
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	Occupational Therapy: 80 visit limit/year. Speech Therapy: 80 visit limit/year.
	<a href="#">Habilitation services</a>	\$30 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	Physical Therapy: 80 visit limit/year. <a href="#">Deductible</a> does not apply to <a href="#">copayment</a> .
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required. 150 days per year maximum
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
If your child needs dental or eye care	Children's eye exam	No Charge	50% <a href="#">coinsurance</a>	Limit of 1 routine exam per year.
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	None.

### 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
- Weight loss programs
- Dental Care (Adult)
- Bariatric Surgery
- Acupuncture
- Long-term care
- Non-emergency care when traveling outside the U.S.

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

- Infertility Treatment (correction of physiological abnormalities)
- Routine Eye Care (one exam/year)
- Routine Foot Care
- Emergency care when traveling outside the U.S.
- Chiropractic Care
- Private Duty Nursing (inpatient only)

**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: 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). 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: 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 844-682-4031]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-682-4031]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-682-4031]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 844-682-4031]

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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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist Copayment</a>	\$30
■ <a href="#">Hospital (facility) Copayment</a>	\$50
■ <a href="#">Other Coinsurance</a>	30%

This EXAMPLE event includes services like:  
[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic test](#) (*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:**

Cost Sharing	
Deductibles	\$3,000
Copayments	\$60
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,920</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist Copayment</a>	\$30
■ <a href="#">Hospital (facility) Copayment</a>	\$50
■ <a href="#">Other Coinsurance</a>	30%

This EXAMPLE event includes services like:  
 Primary care physician office visits (*including disease education*)  
[Diagnostic test](#) (*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:**

Cost Sharing	
Deductibles	\$900
Copayment	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,920</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist Copayment</a>	\$30
■ <a href="#">Hospital (facility) Copayment</a>	\$50
■ <a href="#">Other Coinsurance</a>	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:**

Cost Sharing	
Deductibles	\$2,000
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,300</b>

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