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, contact MedBen's Customer Service Department at 1-800-686-8425 or mbaccess.medben.com (select MedBen Access). 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 1-877-267-2323 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	None.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	Deductibles do not apply to any expenses under this plan, but a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Not Applicable.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,000 for employee only; $3,750 for employee plus 1 dependent; and $5,500 for family coverage, per calendar year for medical copayments only. An overall limit of $8,550 per individual and $17,100 per family applies. This includes the initial limit above and Rx copayments.	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 and charges 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?	Not Applicable.	This plan does not use a provider network, except in connection with certain organ/transplant benefits and pharmacy benefits. You can receive covered services from any provider.*
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	$30 copayment	Includes telehealth. Office-based surgery/injections & administration - $30 copayment for PCP and $45 copayment for a specialist. Allergy testing - $45 copayment. Allergy injections - $5 copayment. All other services – no charge.
	Specialist visit	$45 copayment	
	Preventive care/screening/ immunization	$45 copayment for routine hearing exams (if not included in the pediatric preventive care recommendations); all other - no charge	Cologuard testing - 1 per 3 year period. Visual acuity screenings/hearing exams included in pediatric care recommendations through age 21 only. Other hearing exams - 1 per calendar year. Tobacco cessation counseling - 2 attempts to stop tobacco use per year with up to 4 sessions per attempt. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what the plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	None.
	Imaging (CT/PET scans, MRIs)	CT Scans - $150 copayment and MRI / PET Scans / Nuclear Medicine - $250 copayment	Pre-certification recommended for CT, PET & MRI. Through Evocare program - No charge for radiology services.
If you need drugs to treat your illness or condition For more information about prescription drug coverage that is available through Ventegra, contact MedBen's Customer Service Department at 1-800-686-8425.	Generic drugs	$10 copayment (30 day supply retail); $20 copayment (60 day supply retail); $30 copayment (90 day supply retail or mail order)	No charge for over-the-counter non-sedating antihistamines and certain preventive drugs with a physician's prescription. See the plan document for listing. Certain brand name drugs are not covered under this plan. See the plan document for a listing. Member is responsible for the difference in cost if a brand name drug is obtained when a generic is available, unless the physician has indicated that the prescription must be dispensed as written. TruDataRx aligns prescription coverage with best-in-class evidence-based medicine for select health conditions. Prescriptions for these conditions will have two new copay tiers that differ from current prescription tiers. See plan for details. The plan may waive the charge for specialty medications with a copayment of $200+ when the manufacturer does not offer any copayment assistance for such medication under the plan's pharmacy benefit program.
	Preferred brand drugs (includes high cost generic drugs)	20% coinsurance up to $200 (30 day supply retail); 20% coinsurance up to $400 (60 day supply retail); 20% coinsurance up to $600 (90 day supply retail or mail order)	
	Non-preferred brand drugs	20% coinsurance + $50 up to $200 (30 day supply retail); 20% coinsurance + $100 up to $400 (60 day supply retail); 20% coinsurance + $150 up to $600 (90 day supply retail or mail order)	
	Specialty drugs	Applicable copayment listed above applies.	

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)	$250 copayment	Pre-certification recommended for non-office based procedures.
	Physician/surgeon fees	No charge	None.
If you need immediate medical attention	Emergency room care	$250 copayment	Includes facility and physician, per visit. Copayment waived if admitted.
	Emergency medical transportation	$50 copayment	Includes air ambulance.
	Urgent care	$50 copayment	Includes facility and physician.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment, per admission	Pre-certification recommended.
	Physician/surgeon fees	No charge	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment, for visits, counseling & intensive outpatient psychotherapy; all other – same as other conditions	None.
	Inpatient services	$500 copayment, per admission	Pre-certification recommended.
If you are pregnant	Office visits	$30 copayment applies to initial visit only	Dependent child pregnancy covered.
	Childbirth/delivery professional services	No charge	
	Childbirth/delivery facility services	$500 copayment, per admission	Pre-certification recommended after 48 hours for vaginal delivery, or 96 hours following a c-section.
If you need help recovering or have other special health needs	Home health care	No charge	Limited to 60 visits per calendar year. Pre-certification recommended (including Home IV infusion).
	Rehabilitation services	$30 copayment, per date of service for pulmonary rehab, cognitive/occupational/ physical/speech therapy; $45 copayment for cardiac rehab, spinal manipulations and diabetic self-management training	Limited to 60 visits, combined, per calendar year for spinal manipulation, pulmonary rehabilitation, and cognitive, physical, speech and occupational therapies. Limited to 36 visits per calendar year for cardiac rehabilitation.
	Habilitation services	Not covered	This exclusion does not apply to expenses related to ADD, ADHD or autism spectrum disorders.
	Skilled nursing care	$500 copayment, per admission; $100 copayment if extended care facility	Limited to 60 days per calendar year (combined). Pre-certification recommended.
	Durable medical equipment	$50 copayment	Rental or purchase, at plan administrator's discretion. Pre-certification recommended if over $1,500.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Hospice services	No charge	Pre-certification recommended for inpatient. Includes bereavement counseling.
If your child needs dental or eye care	Children's eye exam	No charge if included in the pediatric preventive care recommendations	None.
	Children's glasses	$50 copayment	Covered when following surgery only, limited to 1 pair.
	Children's dental check-up	Not covered	None.

***Covered Expenses will be based on a percentage of the Medicare allowable rate. Please see the plan document for additional information.**

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,
- Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances,
- Cosmetic Surgery, except as specifically listed in the plan as covered,
- Dental care (Adult and child). Certain services are covered. See plan for details,
- Infertility Treatment,
- Long Term Care,
- Non-emergency care when traveling outside the U.S., unless travel was for the purpose of obtaining treatment,
- Private Duty Nursing,
- Routine eye care (Adult),
- Routine Foot Care, unless due to an underlying medical condition and
- Weight Loss Programs.

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

- Bariatric Surgery, if medically necessary for the treatment of morbid obesity, limited to 1 surgical procedure per lifetime,
- Chiropractic Care. Spinal manipulation limited to 60 visits per calendar year, combined with pulmonary rehabilitation, and cognitive, physical, speech and occupational therapies, and
- Hearing aids up to age 18, limited to 1 pair every 3 years.

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 Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-866-267-2323 x61565 or 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 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: MedBen's Customer Service Department at 1-800-686-8425 or mbaccess.medben.com (select MedBen Access). Additionally, a consumer assistance program may be available in your state to help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and at http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

* For more information about limitations and exceptions, see the plan or policy document at **mbaccess.medben.com** (select MedBen Access).

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 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:
Para obtener asistencia en Español, llame al 1-800-862-6704.

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** $0
- **Primary Care Physician *copayment*** $30
- **Hospital (facility) *copayment*** $500
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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

- **The plan's overall deductible** $0
- **Specialist *copayment*** $45
- **Hospital (facility) *copayment*** $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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,430**

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

- **The plan's overall deductible** $0
- **Specialist *copayment*** $45
- **Hospital (facility) *copayment*** $250
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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