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 833-644-1298. 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 www.cciio.cms.gov or call 833-644-1298 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network $1,450/person or $2,900/family. Out-of-Network $2,750/person or $5,500/family.	Generally, you must pay all 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. In-Network preventive care services 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 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 $3,500/person or $7,000/family. Out-of-Network $7,000/person or $14,000/family.	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, certain specialty drugs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Certain specialty drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket limits.
Will you pay less if you use a network provider?	Yes. See www.MyHealthToolkitKC.com or call 1-800-810-BLUE (2583) for a list of network providers.	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	20% Coinsurance	40% Coinsurance	Teladoc visits are covered.
	Specialist visit	20% Coinsurance	40% Coinsurance	Teladoc visits for dermatology and nutrition are covered.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	See www.healthcare.gov for preventive care guidelines. There may be additional benefits available. See your Employer for details. 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)	20% Coinsurance	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Preauthorization may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.express-scripts.com/	Generic drugs (Retail)	$10 Copayment	Not Covered	None
	Generic drugs (Mail Order)	$20 Copayment	Not Covered	None
	Preferred brand drugs (Retail)	20% Coinsurance	Not Covered	$25 min/$50 max
	Preferred brand drugs (Mail Order)	$75 Copayment	Not Covered	None
	Non-preferred brand drugs (Retail)	30% Coinsurance	Not Covered	$40 min/$100 max
	Non-preferred brand drugs (Mail Order)	$120 Copayment	Not Covered	None
	Specialty drugs	Follow tier structure as above	Not Covered	Preauthorization may be required. Please see "Important Questions" regarding the plan's out-of-pocket limit.

[* For more information about limitations and exceptions, see the plan or policy document at www.MyHealthToolkitKC.com.]

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Preauthorization is required for some outpatient surgeries. Penalty for not obtaining preauthorization is $250.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None
If you need immediate medical attention	Emergency room care	$150 Copayment/ visit then 20% Coinsurance	$150 Copayment/ visit then 20% Coinsurance	Copayment will be waived if admitted.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None
	Urgent care	20% Coinsurance	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Preauthorization is required. Penalty for not obtaining preauthorization is $250.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	40% Coinsurance	Teladoc visits for behavioral health are covered.
	Inpatient services	20% Coinsurance	40% Coinsurance	Preauthorization is required. Penalty for not obtaining preauthorization is $250.
If you are pregnant	Office visits	20% Coinsurance	40% Coinsurance	Preauthorization for facility services is required. Penalty for not obtaining preauthorization is $250. Depending on the type of services, a coinsurance or deductible may apply. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	60 visits/benefit year. Preauthorization is required. Penalty for not obtaining preauthorization is denial of all charges.
	Rehabilitation services	20% Coinsurance	40% Coinsurance	60 combined visits/benefit year for Occupational Therapy, Physical Therapy and Speech Therapy. Preauthorization required after 60th visit. Cardiac & pulmonary therapy covered.

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	20% Coinsurance	40% Coinsurance	60 combined visits/benefit year for Occupational Therapy, Physical Therapy and Speech Therapy. Preauthorization required after 60th visit. Cardiac & pulmonary therapy covered.
	Skilled nursing care	20% Coinsurance	40% Coinsurance	100 visits/benefit year. Preauthorization is required. Penalty for not obtaining preauthorization is $250.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Purchase or rentals of $500 or more require preauthorization. Penalty for not obtaining preauthorization is denial of all charges. Hearing aids are limited to 2 hearing aids, every 3 years. Wigs are limited to 1 unit, every 36 months.
	Hospice services	20% Coinsurance	40% Coinsurance	Preauthorization is required. Penalty for not obtaining preauthorization is $250 for In-Network inpatient services and denial of all charges for In-Network outpatient and all Out-of-Network services.
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	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
- Dental Care (Adult)
- Dental Care (Child)
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Eye Care (Child)
- Routine Foot Care
- Weight Loss Programs
- 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.)

- Acupuncture
- Chiropractic Care, 60 visits/benefit year combined with other therapies
- Hearing Aids
- Infertility Treatment (through Progyny only, call 866-988-5259 to activate benefits)
- Private-Duty Nursing, if part of pre-authorized Home Health Care
- Bariatric Surgery

[* For more information about limitations and exceptions, see the plan or policy document at www.MyHealthToolkitKC.com.]

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa. 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: 833-644-1298 or visit us at www.MyHealthToolkitKC.com, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

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:

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 833-644-1298.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 833-644-1298.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833-644-1298.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 833-644-1298 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 833-644-1298.

Spanish (Español): Para obtener asistencia en Español, llame al 833-644-1298.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-644-1298.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 833-644-1298.

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	**$1,450**
Specialist *[cost sharing]*	**20%**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

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	$1,450
Copayments	$0
Coinsurance	$2,050
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,570**

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

The plan's overall deductible	**$1,450**
Specialist *[cost sharing]*	**20%**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

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	$1,450
Copayments	$310
Coinsurance	$550
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,330**

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

The plan's overall deductible	**$1,450**
Specialist *[cost sharing]*	**20%**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**20%**

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	$1,450
Copayments	$150
Coinsurance	$180
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,790**

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