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, www.coupehealth.com. 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 1-800-882-5158 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	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.	This plan does not have a deductible.
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?	Tier 1, Tier 2 and Tier 3 Preferred Providers combined: $8,000/individual or $16,000/family per benefit period. Nonpreferred Provider: Unlimited/individual or Unlimited/family per benefit period.	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?	Penalties for failure to obtain pre-certification for services, premiums, balance-billing charges, and 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 www.coupehealth.com or call 1-800-882-5158 for a list of network providers.	You pay the least if you use a tier 1 preferred provider. You pay more if you use a tier 2 or tier 3 preferred provider . You will pay the most if you use a tier 4 nonpreferred 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 preferred provider might use a tier 4 nonpreferred 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
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay less)	Tier 3 Preferred Provider (You will pay more)	Tier 4 Nonpreferred 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	$30 copayment	$60 copayment	$145 copayment	$175 copayment	None.
	Specialist visit	$75 copayment	$150 copayment	$325 copayment	$390 copayment	Chiropractic care limited to 20 visits per benefit period.
	Preventive care/screening/immunization	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	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)	Basic labs $50 copayment; X-rays and Advanced labs $205 copayment	Basic labs $100 copayment; X-rays and Advanced labs $270 copayment	Basic labs $150 copayment; X-rays and Advanced labs $455 copayment	Basic labs $350 copayment; X-rays and Advanced labs $545 copayment	None.
	Imaging (CT/PET scans, MRIs)	$400 copayment	$535 copayment	$910 copayment	$1,090 copayment	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay less)	Tier 3 Preferred Provider (You will pay more)	Tier 4 Nonpreferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call 1-866-644-7527.	Generic drugs	Retail: 25% coinsurance (min $10/max $45) Mail order: 25% coinsurance (min $25/max $115)				Copay applies to a 30-day supply Retail and Specialty drugs or 31-90 day supply Mail-Order prescription. Mail-Order must be used after 2 fills for maintenance drugs. Copay does not apply to preventive drugs required by the Affordable Care Act, or certain cholesterol, blood pressure, diabetes and insulin. If you use a non-participating pharmacy, you must also pay the difference in cost between a participating and the non-participating pharmacy. If you purchase a brand name drug when the physician has indicated a generic drug can be dispensed, you must pay difference in cost.
	Preferred drugs	Retail: 40% coinsurance (min $40/max $100) Mail order: 40% coinsurance (min $100/max $250)				
	Non-preferred drugs	Retail: 50% coinsurance (min $75/max $150) Mail order: 50% coinsurance (min $185/max $375)				
	Specialty drugs	If not covered by PrudentRx $210 copayment; If covered by PrudentRx 30% coinsurance				

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay less)	Tier 3 Preferred Provider (You will pay more)	Tier 4 Nonpreferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,500 copayment	$1,990 copayment	$3,365 copayment	$4,040 copayment	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	None.
If you need immediate medical attention	Emergency room care	$1,200 copayment	Tier 1 preferred provider benefit applies	Tier 1 preferred provider benefit applies	Tier 1 preferred provider benefit applies	Copay waived if admitted.
	Emergency medical transportation	$1,200 copayment	Tier 1 preferred provider benefit applies	Tier 1 preferred provider benefit applies	Tier 1 preferred provider benefit applies	None.
	Urgent care	$150 copayment	$150 copayment	$150 copayment	$150 copayment	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$4,400 copayment	$5,800 copayment	$8,000 copayment	$11,000 copayment	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office $30 copayment; Other Outpatient Services: $1,500 copayment	Office $60 copayment; Other Outpatient Services: $1,990 copayment	Office $145 copayment; Other Outpatient Services: $3,365 copayment	Office $175 copayment; Other Outpatient Services: $4,040 copayment	None.
	Inpatient services	$4,400 copayment	$5,800 copayment	$8,000 copayment	$11,000 copayment	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.

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

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay less)	Tier 3 Preferred Provider (You will pay more)	Tier 4 Nonpreferred Provider (You will pay the most)	
If you are pregnant	Office visits	$30 copayment	$60 copayment	$145 copayment	$175 copayment	Dependent daughters are covered for this benefit. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	
	Childbirth/delivery facility services	$4,400 copayment	$5,800 copayment	$8,000 copayment	$11,000 copayment	
If you need help recovering or have other special health needs	Home health care	$115 copayment	$155 copayment	$260 copayment	$315 copayment	Home health care visits and private duty nursing combined limited to 120 visits per benefit period. Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
	Rehabilitation services	$50 copayment	$100 copayment	$150 copayment	$250 copayment	Cardiac rehabilitation limited to 36 visits per benefit period. Respiratory, physical, occupational, and speech therapy combined limited to 90 visits per benefit period.
	Habilitation services	$50 copayment	$100 copayment	$150 copayment	$250 copayment	
	Skilled nursing care	$4,400 copayment	$4,895 copayment	$8,000 copayment	$10,560 copayment	Skilled nursing care and rehabilitation inpatient combined limited to 90 days per benefit period. Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2 (You will pay less)	Tier 3 (You will pay more)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs (continued)	Durable medical equipment	$230 copayment	$310 copayment	$520 copayment	$625 copayment	None.
	Hospice services	$460 copayment	$615 copayment	$1,035 copayment	$1,245 copayment	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $500 penalty of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	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.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care
- 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
- Chiropractic care, limited to 20 visits per benefit period.
- Hearing aids, limited to $5,000 every 36 months.
- Infertility treatment, limited to $2,000 per benefit period.
- Private-duty nursing, limited to 120 visits per benefit period, combined with home health care.

* For more information about limitations and exceptions, see the plan or policy document at www.coupehealth.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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 1-800-882-5158.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-882-5158.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-882-5158.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-882-5158 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-882-5158.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-882-5158.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-882-5158.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-882-5158.

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 (Tier 1 preferred provider)	$0
■ Specialist copayment	$75
■ Hospital (facility) copayment	$4,400
■ Other copayment	$1,500

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	$7,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,960**

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

■ The plan's overall (Tier 1 preferred provider)	$0
■ Specialist copayment	$75
■ Hospital (facility) copayment	$4,400
■ Other copayment	$1,500

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	$1,200
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,920**

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

■ The plan's overall (Tier 1 preferred provider)	$0
■ Specialist copayment	$75
■ Hospital (facility) copayment	$4,400
■ Other copayment	$1,500

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(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	$2,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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