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, visit www.customdesignbenefits.com or call 1-800-598-2929. 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 1-866-444-EBSA (3272) 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 an overall 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?	**$2,500** individual / **$5,000** 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, health care this plan doesn't cover and penalties for failure to obtain precertification. Copays for certain specialty prescription drugs considered non-essential health benefits under the plan. The copays for these drugs (though manufacturer copay assistance programs may support some fills at no remaining cost to you) will not apply towards satisfying your out-of-pocket maximum or any applicable deductible.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Not applicable.	This plan does not use a provider network. 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 copay/visit	None
	Specialist visit	$50 copay/visit	None
	Preventive care/screening/ immunization	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay/visit	Precertification required for CT/PET Scans and MRIs or benefits will be denied.
	Imaging (CT/PET scans, MRIs)	Copay/test if performed in freestanding facility: CT Scan: $250 MRI: $250 Copay/test if outpatient hospital: CT Scan: $500 MRI: $500 PET Scans: $500	

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

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Tier 1 – Typically Generic	Copays/prescription: Retail — $0 Retail/mail order — $0 (mail order or Smart 90)	After the Calendar Year out-of-pocket limit has been met, the Plan will pay for prescription drugs at 100%. Plan covers up to a 34- day supply (retail prescription); 90-day supply (mail order and Smart90). Patient must pay the cost difference between the brand and generic drug in addition to your copay or coinsurance. The Plan covers up to a 34-day supply for specialty prescription drugs. Patient may call the pharmacy benefit manager with questions regarding quantity limitations or prior authorization. *Copays for certain specialty prescription drugs considered non- essential health benefits under the plan bypass your out-of-pocket limit. Please see "Important Questions" regarding the plan's out-of-pocket limit. See plan document for additional information on the SaveonSP Program. .
	Tier 2 - Brand Preferred	Copays/prescription: Retail — $35 Retail/mail order — $85 (mail order or Smart 90)	
	Tier 3 - Non-preferred Brand drugs	Copays/prescription: Retail — not covered Retail/mail order — not covered	
	Tier 4 – Typically Preferred Specialty drugs	$75 copays/prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit max of 3 days	Precertification required unless performed in physician's office or benefits will be denied.
	Physician/surgeon fees	$0 copay/visit	None
If you need immediate medical attention	Emergency room care	$200 copay/visit	Emergency room copay waived if admitted.
	Emergency medical transportation	$250 copay/use — ground $500 copay/use — air	
	Urgent care	$40 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/day (3 day maximum)	Precertification required or benefits will be denied.
	Physician/surgeon fees	$0 copay/visit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	None
	Inpatient services	$250 copay/day (3 day maximum)	Precertification required or benefits will be denied.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	$0 copay/visit	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$0 copay/visit	
	Childbirth/delivery facility services	$250 copay/day (3 day maximum)	
If you need help recovering or have other special health needs	Home health care	$50 copay/visit	60 visits/calendar year. Precertification required or benefits will be denied.
	Rehabilitation services	$50 copay/visit	60 visits/calendar year combined for physical therapy, speech therapy, and occupational therapy. Precertification required or benefits will be denied.
	Habilitation services	$50 copay/visit	
	Skilled nursing care	$100 copay	Precertification required or benefits will be denied.
	Durable medical equipment	20% coinsurance	Examples of exclusions: vehicle modifications, home modifications, exercise, and bathroom equipment. Precertification required or benefits will be denied.
	Hospice services	$0 copay/visit	None
If your child needs dental or eye care	Children's eye exam	No charge	Routine exam under preventive care
	Children's glasses	Not covered	None
	Children's dental check-up	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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Foot Care

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

- Chiropractic Care 24 visits/benefit period
- Hearing Aids $500 Maximum/benefit period
- Routine eye exam (Adult) one/24 months

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: 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: Custom Design Benefits at 1-800-598-2929 or customdesignbenefits.com or the U.S. Department of Labor, 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 1-800-598-2929.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-598-2929.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-598-2929.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-598-2929.]

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

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

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**
Specialist copay	**$50**
Hospital (facility) copay	**$250**
Other coinsurance	**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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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 copay	**$50**
Hospital (facility) copay	**$250**
Other coinsurance	**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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$320**

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

The plan's overall deductible	**$0**
Specialist copay	**$50**
Hospital (facility) copay	**$250**
Other coinsurance	**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	$0
Copayments	$1000
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1050**

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

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