



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 844-302-7774. 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 844-302-7774 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not applicable.	This <a href="#">plan</a> does not have a <a href="#">deductible</a> .
Are there other <a href="#">deductibles</a> for specific services?	Not applicable.	This <a href="#">plan</a> does not have a <a href="#">deductible</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not applicable.	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> .
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not applicable.	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Not applicable.	This <a href="#">plan</a> only covers <a href="#">preventive</a> care.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Not applicable.	This <a href="#">plan</a> only covers <a href="#">preventive</a> care.



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	Not Covered		None	
	<u>Specialist</u> visit	Not Covered		None	
	<u>Preventive care/screening/</u> immunization	No Charge	Not Covered	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)	Not Covered		None	
	Imaging (CT/PET scans, MRIs)	Not Covered		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://NSHABenefits.com">NSHABenefits.com</a>	Generic drugs	Retail & Mail Order: Not Covered		<u>Cost sharing</u> does not apply for <u>preventive Prescriptions</u> .	
	Preferred brand drugs	Retail & Mail Order: Not Covered			
	Non-preferred brand drugs	Retail & Mail Order: Not Covered			
	<u>Specialty drugs</u>	Retail & Mail Order: Not Covered			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered		None	
	Physician/surgeon fees	Not Covered		None	
If you need immediate medical attention	<u>Emergency room care</u>	Not Covered		None	
	<u>Emergency medical transportation</u>	Not Covered		None	
	<u>Urgent care</u>	Not Covered		None	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered		None	
	Physician/surgeon fees	Not Covered		None	

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 need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered		None.
	Inpatient services	Not Covered		None.
If you are pregnant	Office visits	Not Covered		<u>Cost sharing</u> does not apply for <u>preventive</u> services. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	Not Covered		
	Childbirth/delivery facility services	Not Covered		
If you need help recovering or have other special health needs	<u>Home health care</u>	Not Covered		None
	<u>Rehabilitation services</u>	Not Covered		None
	<u>Habilitation services</u>	Not Covered		None
	<u>Skilled nursing care</u>	Not Covered		None
	<u>Durable medical equipment</u>	Not Covered		None
	<u>Hospice services</u>	Not Covered		None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limit of 1 routine exam per year.
	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.)

- Non-Preventive care

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

- Preventive care

**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? No**

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 844-302-7774

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-302-7774

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-302-7774

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 844-302-7774

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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>	\$0
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$0
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	100%
■ Other [ <a href="#">cost sharing</a> ]	100%

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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$12,731</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>	\$0
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$0
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	100%
■ Other [ <a href="#">cost sharing</a> ]	100%

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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$7,389</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>	\$0
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	00
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	100%
■ Other [ <a href="#">cost sharing</a> ]	100%

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>\$1,368</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,368</b>

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