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, 1.888.816.3096. 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. https://www.healthcare.gov/sbc-glossary or call 1.888.816.3096 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** Single/**$1,000** Family For all networks	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. Primary care and **specialist** visits, **preventive services,** diagnostics, urgent care and **prescriptions** 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 certain **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?	**$3,000** Single/**$6,000** Family For all networks	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, **premiums**, **balance billing** charges, amounts in excess of the Referenced Based Price 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. For a list of practitioner and ancillary network providers, please go to www.hstconnect.com or call 800.440.7427	This **plan** uses a **provider network** for practitioner and ancillary providers only. However, physician and ancillary claims priced at the **out-of-network** level will be sent to HST for pricing at the **in-network** level. 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**.

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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 **copay**/visit, **deductible** does not apply	TelaDoc visits through (800) 835-2362 and through the TelaDoc application are covered at $0 **copay**.
	Specialist visit	$20 **copay**/visit, **deductible** does not apply	TelaDoc visits through (800) 835-2362 and through the TelaDoc application are covered at $0 **copay**
	Preventive care/screening/ immunization	No charge, **deductible** does not apply	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)	20% **coinsurance**, **deductible** does not apply	None
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**, **deductible** does not apply	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.southernscripts.net or at (800) 710-9341.	Generic drugs	$10 **copay** for 34-day supply (retail) $30 **copay** for 90-day supply (retail) $20 **copay** for 90-day supply (mail order)	Covers up to 90-day supply for retail prescription and 90-day supply for mail order. **Deductible** does not apply.
	Preferred brand drugs	$30 **copay** for 34-day supply (retail) $90 **copay** for 90-day supply (retail) $60 **copay** for 90-day supply (mail order)	
	Non-preferred brand drugs	$50 **copay** for 34-day supply (retail) $150 **copay** for 90-day supply (retail) $100 **copay** for 90-day supply (mail order)	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Specialty drugs	$10 **copay** for 30-day supply (generic) $30 **copay** for 30-day supply (preferred) $50 **copay** for 30-day supply (non-preferred)	Please contact Southern Scripts, your specialty pharmacy, for more information on what is covered. **Deductible** does not apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	**Preauthorization** is required.
	Physician/surgeon fees	20% **coinsurance**	None
If you need immediate medical attention	Emergency room care	$200 **copay**/visit then 20% **coinsurance**	**Copay** waived if admitted
	Emergency medical transportation	20% **coinsurance**	None
	Urgent care	$20 **copay**/visit, **deductible** does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	**Preauthorization** is required
	Physician/surgeon fees	20% **coinsurance**	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 **copay**/visit, **deductible** does not apply	TelaDoc visits through (800) 835-2362 and through the TelaDoc application are covered at $0 **copay**.
	Inpatient services	20% **coinsurance**	**Preauthorization** is required. Residential treatment is covered.
If you are pregnant	Office visits	$20 **copay**/visit, **deductible** does not apply	Cost sharing does not apply to certain **preventive** services. Depending on the type of services, **deductible**, **copayment** or **coinsurance** may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). **Preauthorization** required for elective caesarean sections and inductions.
	Childbirth/delivery professional services	20% **coinsurance**	
	Childbirth/delivery facility services	20% **coinsurance**	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% **coinsurance**	Limited to a 120-day calendar year maximum. **Preauthorization** is required.
	Rehabilitation services	20% **coinsurance**	**Preauthorization** is required for inpatient. Outpatient benefits are limited to a 25 visit per calendar year maximum. Swim therapy is not covered. Neurodevelopmental therapy is covered with no age limit.
	Habilitation services	Not Covered	None
	Skilled nursing care	20% **coinsurance**	Limited to a 100-day calendar year maximum. **Preauthorization** is required
	Durable medical equipment	20% **coinsurance**	**Preauthorization** is required for DME that exceeds $1,000.
	Hospice services	20% **coinsurance**	**Preauthorization** is required
If your child needs dental or eye care	Children's eye exam	Not covered	None
	Children's glasses	Not covered	None
	Children's dental check-up	Not included with medical	If enrolled, please refer to your plan document.

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.)

- Bariatric surgery
- Children's eye exam
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Gene Therapy
- Infertility treatment
- Long-term
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (except for diabetics)
- Weight loss programs

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

- Acupuncture
- ABA Therapy
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.

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 or the Department of Health and Human Services at 1.877.267.2323 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 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: The Health Plan Appeals Coordinator at 1.888.816.3096 or the 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 1.855.577.7123

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.855.577.7123

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1.855.577.7123

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1.855.577.7123

*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 deductible	**$500**
Specialist *copay*	**$20**
Hospital (facility) *coinsurance*	**20%**
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	$500.00
Copayments	$0.00
Coinsurance	$2,390.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$2,890.00**

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

The plan's overall deductible	**$500**
Specialist *copay*	**$20**
Hospital (facility) *coinsurance*	**20%**
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	$500.00
Copayments	$100.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$600.00**

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

The plan's overall deductible	**$500**
Specialist *copay*	**$20**
Hospital (facility) *coinsurance*	**20%**
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	$500.00
Copayments	$240.00
Coinsurance	$380.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$1,120.00**

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