
 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, contact HealthEZ at 1-855-290-1414. 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/pdf/sbcuniformglossary.pdf](http://www.dol.gov/ebsa/pdf/sbcuniformglossary.pdf) or call 1-855-290-1414 to request a copy.

| Important Questions   | Answers   | Why This Matters:  |
|---|---|--|
| <p>What is the overall <a href="#">deductible</a>?</p>                                | <p><b>\$2,000</b> individual/ <b>\$4,000</b> family for <u>in-network</u> providers. <b>\$4,000</b> individual/ <b>\$8,000</b> family for <u>out-of-network</u> providers.</p>    | <p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.<br/> <b>Deductible year runs 01/01 to 12/31.</b></p>   |
| <p>Are there services covered before you meet your <a href="#">deductible</a>?</p>    | <p>Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u>.</p>  | <p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <a href="#">plan</a> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>                                  |
| <p>Are there other <a href="#">deductibles</a> for specific services?</p>             | <p>No.</p>  | <p>You don't have to meet <u>deductibles</u> for specific services.</p>  |
| <p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p> | <p><b>\$6,350</b> individual/ <b>\$12,700</b> family for <u>in-network</u> providers. <b>\$14,000</b> individual/ <b>\$28,000</b> family for <u>out-of-network</u> providers.</p> | <p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>   |
| <p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>               | <p>Premiums, <u>balance-billed</u> charges, and health care this <a href="#">plan</a> does not cover.</p>   | <p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>   |
| <p>Will you pay less if you use a <a href="#">network provider</a>?</p>               | <p>Yes. See <a href="http://www.pinkjeeptennesssee.com">www.pinkjeeptennesssee.com</a> or call 1-855-290-1414 for a list of <u>in-network</u> providers.</p>                      | <p>This <a href="#">plan</a> uses a provider <u>network</u>. You will pay less if you use a <u>provider</u> in the plan's <u>network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <a href="#">plan</a> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p> |
| <p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>    | <p>No.</p>  | <p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>   |

 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<br>(You will pay the least)                | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | \$35/Visit  | 50% <a href="#">Coinsurance</a>                    | <a href="#">Deductible</a> does not apply.  |
|  | <a href="#">Specialist</a> visit                       | \$35/Visit  | 50% <a href="#">Coinsurance</a>                    | <a href="#">Deductible</a> does not apply.  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge   | 50% <a href="#">Coinsurance</a>                    | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your plan will pay for. |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge   | 50% <a href="#">Coinsurance</a>                    | None  |
|  | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">Coinsurance</a>                             | 50% <a href="#">Coinsurance</a>                    | Precertification required   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.pinkjeepebenefits.com">www.pinkjeepebenefits.com</a> . | Generic drugs  | Retail: \$10/Prescription<br>Mail order: \$30/Prescription  |  | Retail and mail order available up to 90-day supply. <a href="#">Deductible</a> does not apply.   |
|  | Preferred brand drugs                                  | Retail: \$35/Prescription<br>Mail order: \$105/Prescription |  | Retail and mail order available up to 90-day supply. <a href="#">Deductible</a> does not apply.   |
|  | Non-preferred brand drugs                              | Retail: \$60/Prescription<br>Mail order: \$180/Prescription |  | Retail and mail order available up to 90-day supply. <a href="#">Deductible</a> does not apply.   |
|  | <a href="#">Specialty drugs</a>                        | Retail & Mail order: \$80/Prescription                      |  | Retail and mail order available up to 30-day supply. <a href="#">Deductible</a> does not apply.   |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)         | 20% <a href="#">Coinsurance</a>                             | 50% <a href="#">Coinsurance</a>                    | <a href="#">Preauthorization</a> required for procedures performed outside of a physician's office.   |
|  | Physician/surgeon fees                                 | 20% <a href="#">Coinsurance</a>                             | 50% <a href="#">Coinsurance</a>                    |   |
| If you need immediate medical attention  | <a href="#">Emergency room care</a>                    | \$250/Visit   | \$250/Visit  | <a href="#">Deductible</a> does not apply.  |
|  | <a href="#">Emergency medical transportation</a>       | 20% <a href="#">Coinsurance</a>                             | 50% <a href="#">Coinsurance</a>                    | True emergency covered at in-network level.   |
|  | <a href="#">Urgent care</a>                            | \$50/Visit  | 50% <a href="#">Coinsurance</a>                    | <a href="#">Deductible</a> does not apply.  |
| If you have a hospital stay  | Facility fee (e.g., hospital room)                     | 20% <a href="#">Coinsurance</a>                             | 50% <a href="#">Coinsurance</a>                    | <a href="#">Preauthorization</a> required   |
|  | Physician/surgeon fees                                 | 20% <a href="#">Coinsurance</a>                             | 50% <a href="#">Coinsurance</a>                    | <a href="#">Preauthorization</a> required   |

\* For more information about limitations and exceptions, see the plan or policy document at [www.pinkjeepebenefits.com](http://www.pinkjeepebenefits.com).

| Common Medical Event  | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|---|---|--|--|---|
|   |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$35/Visit                                   | 50% <u>Coinsurance</u>                             | <u>Deductible</u> does not apply.   |
|   | Inpatient services                        | 20% <u>Coinsurance</u>                       | 50% <u>Coinsurance</u>                             | <u>Preauthorization</u> required  |
| If you are pregnant   | Office visits                             | No Charge                                    | 50% <u>Coinsurance</u>                             | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|   | Childbirth/delivery professional services | 20% <u>Coinsurance</u>                       | 50% <u>Coinsurance</u>                             |   |
|   | Childbirth/delivery facility services     | 20% <u>Coinsurance</u>                       | 50% <u>Coinsurance</u>                             |   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 20% <u>Coinsurance</u>                       | 50% <u>Coinsurance</u>                             | <u>Preauthorization</u> required<br>100 visit limit per year.   |
|   | <a href="#">Rehabilitation services</a>   | \$35/Visit                                   | 50% <u>Coinsurance</u>                             | 25 combined visit limit per year.   |
|   | <a href="#">Habilitation services</a>     | \$35/Visit                                   | 50% <u>Coinsurance</u>                             | <u>Preauthorization</u> required for occupational or speech therapy.<br><u>Preauthorization</u> required for physical therapy visits in excess of annual limit.<br><u>Deductible</u> does not apply.  |
|   | <a href="#">Skilled nursing care</a>      | 20% <u>Coinsurance</u>                       | 50% <u>Coinsurance</u>                             | <u>Preauthorization</u> required<br>60-day limit per year.  |
|   | <a href="#">Durable medical equipment</a> | 20% <u>Coinsurance</u>                       | 50% <u>Coinsurance</u>                             | Precertification required for charges in excess of \$1,000.   |
|   | <a href="#">Hospice services</a>          | 20% <u>Coinsurance</u>                       | 50% <u>Coinsurance</u>                             | <u>Preauthorization</u> required  |
| If your child needs dental or eye care                                    | Children's eye exam                       | No Charge                                    | 50% <u>Coinsurance</u>                             | Limit of 1 routine exam per year.   |
|   | 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
- Weight loss programs
- Hearing Aids
- Bariatric Surgery
- Long-term care
- 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.)**

- Infertility Treatment (correction of physiological abnormalities)
- Routine Eye Care (one visit/yr)
- Emergency care when traveling outside the U.S.
- Chiropractic Care
- Private Duty Nursing (inpatient only)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the [plan](#) at 1-855-290-1414. You may also contact the 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), your state insurance department, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](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: HealthEZ at 1-855-290-1414 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 1-855-290-1414

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-290-1414

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-290-1414

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-290-1414

————— *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](#) \$2,000
- [Specialist](#) copayment \$35
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,840</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,000        |
| Copayments                        | \$110          |
| Coinsurance                       | \$2,480        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,650</b> |

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist](#) copayment \$35
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,460</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,490        |
| Copayments                        | \$1,120        |
| Coinsurance                       | \$370          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$3,040</b> |

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist](#) copayment \$35
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,410</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$760          |
| Copayments                        | \$250          |
| Coinsurance                       | \$170          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,180</b> |