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 Customer Service at 1-855-730-8652. 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 or call 1-855-730-8652 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$850 Individual $2,000 Family	Generally, you must pay all of 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. Prescription drug copays, in-network physician office visits, and preventive care.	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. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,900 Individual $15,800 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Preauthorization penalties, 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.pinnacletpa.com or call 1-855-730-8652 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network 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 network provider might use an out-of-network 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
		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	$50 copay (Deductible waived)	Not covered	Telehealth services are provided through Included Health. Visits with your primary care physician or a specialist will be covered the same as any other office visit.
	Specialist visit	$50 copay (Deductible waived)	Not covered	
	Preventive care/screening/ Immunization	No charge (Deductible waived)	Not covered	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)	40% coinsurance	Not covered	None.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	Preauthorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.prxsolutions.com	Generic drugs	Retail: $30 copay/ prescription. Mail order: $60 copay/prescription (Deductible waived)	Not covered	Retail: Up to a 30-day supply (90-day supply for maintenance drugs). Mail order: Up to a 90-day supply. All contraceptives are covered at 100%. Maintenance drugs must be filled at select retail pharmacies or through mail order.
	Preferred brand drugs	Retail: $100 copay/ prescription. Mail order: $200 copay/prescription (Deductible waived)	Not covered	
	Non-preferred brand drugs	Retail: $150 copay/ prescription. (Deductible waived) Mail order: $300 copay/ prescription	Not covered	
	Specialty drugs	$200 copay/prescription (Deductible waived)	Not covered	Specialty drugs must be filled through the specialty pharmacy. Case management required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay and 25% coinsurance	Not covered	Preauthorization required.
	Physician/surgeon fees	40% coinsurance	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 immediate medical attention	Emergency room care	Emergency: $400 copay and 40% coinsurance. Non-emergency: $500 copay and 40% coinsurance	Emergency: $400 copay and 40% coinsurance. Non-emergency: $500 copay and 40% coinsurance	Copay waived if admitted.
	Emergency medical transportation	40% coinsurance	40% coinsurance	Preauthorization required for non-emergency transport.
	Urgent care	$50 copay (Deductible waived)	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission and 25% coinsurance	Not covered	Preauthorization required.
	Physician/surgeon fees	40% coinsurance	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay (Deductible waived)	Not covered	None.
	Inpatient services	$500 copay/admission and 25% coinsurance	Not covered	Preauthorization required.
If you are pregnant	Office visits	$50 copay (Deductible waived)	Not covered	Office visit and exam only. Depending on type of service, deductible or coinsurance may apply.
	Childbirth/delivery professional services	40% coinsurance	Not covered	None.
	Childbirth/delivery facility services	$500 copay and 25% coinsurance	Not covered	Preauthorization is required for vaginal deliveries requiring more than a 48-hour stay or for cesarean section deliveries requiring more than a 96-hour stay.
If you need help recovering or have other special health needs	Home health care	$50 copay/visit (Deductible waived)	Not covered	Limit: 100 visits per calendar year.
	Rehabilitation services	$50 copay/visit (Deductible waived)	Not covered	Limit: 24 visits per calendar year.
	Habilitation services	Not covered	Not covered	None.
	Skilled nursing care	40% coinsurance	Not covered	Limit: 100 days per calendar year. Preauthorization required.

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)	
	Durable medical equipment	40% coinsurance	Not covered	The plan will cover rental costs up to the purchase price.
	Hospice services	40% coinsurance	Not covered	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None.
	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
- Dental care (Adult)
- Hearing aids
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Routine eye care (Adult)
- 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.)

- Acupuncture (Limit: 12 visits per calendar year)
- Bariatric surgery (Limit: $20,000/lifetime)
- Chiropractic care (Limit: $1,000 per calendar year)
- Private duty nursing

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 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: Pinnacle Claims Management, Inc. at 1-855-730-8652.

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 1-855-730-8652.

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 plan's overall deductible** **$850**
- **Specialist copay** **$50**
- **Hospital (facility) coinsurance** **25%**
- **Other (facility) copayment** **$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	$850
Copayments	$510
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,920**

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

- **The plan's overall deductible** **$850**
- **Specialist copay** **$50**
- **Hospital (facility) coinsurance** **25%**
- **Other (facility) copayment** **$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	$850
Copayments	$1,850
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,750**

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

- **The plan's overall deductible** **$850**
- **Specialist copay** **$50**
- **Hospital (facility) coinsurance** **25%**
- **Other (facility) copayment** **$500**

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	$850
Copayments	$760
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2.110**

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