

 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 <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 <a href="#">deductible</a> ?	In-Network: \$300 Single/ \$600 Family Out-of-Network: \$300 Single/ \$600 Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Emergency room visits, preventive care and urgent care.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-Network: \$1,500 Single/ \$3,000 Family Out-of-Network: \$2,500 Single/ \$5,000 Family	The <a href="#">out-of-pocket limit</a> 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 <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, plan deductible, copayments, penalties and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Call 1.888.816.3096 or visit <a href="http://www.healthplan.org">www.healthplan.org</a> for a list of participating providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance-billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met.

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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	
	<a href="#">Specialist</a> visit	20% coinsurance	40% coinsurance	
	<a href="#">Preventive care/screening/immunization</a>	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. In-network and out-of-network immunizations covered at 100%
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% - CAMC 20% - THP network	40% coinsurance	Hospital other than CAMC – 25% coinsurance
	Imaging (CT/PET scans, MRIs)	20% - CAMC 25% - THP network	40% coinsurance	Pre-certification required. Failure to obtain precertification will result in a \$500 penalty
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">Optumrx.com</a>	Tier 1 - Generic & some Brand	\$5 plus 20% of balance	Not covered	Deductible \$50 single/\$100 family  Brand with Generic Equivalent \$35 plus 20% of balance
	Tier 2 - Preferred Brand drugs	\$20 plus 20% of balance	Not covered	
	Tier 3 - Non-preferred Brand and higher-cost Generic drugs	\$35 plus 20% of balance	Not covered	
	<a href="#">Specialty drugs</a>	20% with max \$100 (non-copay assistance) \$0 (copay assistance)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% - CAMC 25% - THP network	40% coinsurance	Pre-certification required. Failure to obtain precertification will result in a \$500 penalty
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$70 copay/visit (deductible waived) 20% coinsurance after copay if non-emergent	\$70 copay/visit (deductible waived) 40% coinsurance after copay if non-emergent	True emergency. Copay waived if admitted. Non-emergencies subject to deductible.
	<a href="#">Emergency medical transportation</a>	No charge (deductible waived) 20% after deductible (non-emergent)	No charge (deductible waived) 40% (non-emergent)	Emergency transportations only. Non-emergencies subject to deductible
	<a href="#">Urgent care</a>	\$25 copay/visit (deductible waived)	\$25 copay/visit (deductible waived)	

\* For more information about limitations and exceptions, see your Benefits Office for a copy of the plan or policy document.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% - CAMC 25% - THP network	40% coinsurance	Pre-certification required. Failure to obtain precertification will result in a \$500 penalty
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	Pre-certification required. Failure to obtain precertification will result in a \$500 penalty
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	<b>Cost sharing</b> does not apply for <b>preventive services</b> .
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Pre-certification required. Failure to obtain precertification will result in a \$500 penalty
	Childbirth/delivery facility services	20% - CAMC 25% - THP network	40% coinsurance	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% coinsurance	40% coinsurance	Limited to 120 days per calendar year.
	<a href="#">Rehabilitation services</a>	20% - CAMC 25% - THP network	40% coinsurance	Physical and occupational therapy limited to 20 visits per calendar year combined. Visits beyond 20 are covered at 50%.
	<a href="#">Habilitation services</a>	20% - CAMC 25% - THP network	40% coinsurance	
	<a href="#">Skilled nursing care</a>	20% coinsurance	40% coinsurance	Limited to 100 days per calendar year. Pre-certification required. Failure to obtain precertification will result in a \$500 penalty
	<a href="#">Durable medical equipment</a>	20% coinsurance	40% coinsurance	
	<a href="#">Hospice services</a>	20% coinsurance	40% coinsurance	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Refer to vision plan
	Children's glasses	Not covered	Not covered	Refer to vision plan
	Children's dental check-up	Not covered	Not covered	Refer to dental plan

### 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](#).)

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult) - Except removal of impacted wisdom teeth.</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|---|--|---|

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

- Chiropractic care
- Private duty nursing
- Infertility treatment
- Routine eye care (Adult) – Vision coverage only.

**Your Rights to Continue Coverage:** The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that certain *Participants* as specified below may elect to continue participation as a temporary extension of medical coverage (hereinafter “continuation coverage”) upon payment of monthly premium by *Participant* in certain instances where participation in the *Plan* would otherwise be terminated. It is the responsibility of an *Employee*, a participating *Spouse* of *Dependent* (hereinafter referred to as a “qualified beneficiary”) to notify the Human Resource Department in writing of any of the following events within sixty (60) days of the event:

1. Divorce of legal separation from the *Employee* or Retired Employee;
2. Parents' divorce or legal separation;
3. The dependent *Child* ceases to be a *Dependent* as defined;
4. A second qualifying event that occurs while on COBRA;
5. Notice that a qualified beneficiary is entitled to a disability extension; or
6. Notice that a qualified beneficiary is no longer disabled as determined by Social Security Administration.

Failure to notify the Human Resource Department as required will result in the forfeiture of the qualified beneficiary's (as applicable) rights to continuation coverage.

**Your Grievance and Appeals Rights:** If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance you can contact The Health Plan Appeals Coordinator at 888.816.3093.

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

**Does this plan meet the Minimum Value Standards?** Yes.

**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, kwijigo holne' 1.855.577.7123.

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