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, visit www.customdesignbenefits.com or call 1-800-598-2929. 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 1-866-444-EBSA (3272) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	None	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	This plan covers all items and services without a deductible amount. But a copayment may apply.
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 per Individual & $6,000 per Family, per Calendar Year	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?	Premiums, balance-billing charges, plan penalties 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?	Not Applicable	This plan does not use a provider network, except in connection with organ/tissue transplants. 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.

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	$30 copayment	If no office visit charge, no charge for injections, $40 copayment for diagnostic/laboratory services, $75 copayment for surgery, and $50 copayment for medical supplies and other services.
	Specialist visit	$60 copayment	
	Preventive care/screening/ immunization	No charge	Routine visual acuity and hearing examinations through age 21. 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 copayment	$50 copayment for sleep studies in the home. $250 copayment for other sleep studies. PET scans require pre-certification. Covered expenses will be reduced by 50% up to $500 if not obtained.
	Imaging (CT/PET scans, MRIs)	$150 copayment for CT Scan $250 copayment for MRI/PET Scan	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.expressscripts.com	Generic drugs	$15 copayment through retail program $30 copayment through mail order program	Up to a 90 day supply is available through the mail order program. For more information about prescription drug limitations, refer to the summary plan description.
	Preferred brand drugs	$45 copayment through retail program $90 copayment through mail order program	
	Non-preferred brand drugs	$85 copayment through retail program $170 copayment through mail order program	
	Specialty drugs	$100 copayment through retail program $200 copayment through mail order program	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copayment	Pre-certification required for non-office based procedures. Covered expenses will be reduced by 50% up to $500 if not obtained.
	Physician/surgeon fees	No charge	None.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$250 copayment	Emergency copayment waived if admitted. Non-emergency services are not covered in an emergency room.
	Emergency medical transportation	$50 copayment for ground ambulance $250 copayment for air ambulance	
	Urgent care	$60 copayment	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment per day, up to $750 per admission	Pre-certification required. Covered expenses will be reduced by 50% up to $500 if not obtained.
	Physician/surgeon fees	No charge	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Pays same as other conditions	$30 copayment applies to office visit, group/individual counseling and biofeedback. Precertification required for inpatient. Covered expenses will be reduced by 50% up to $500 if not obtained.
	Inpatient services	Pays same as other conditions	
If you are pregnant	Office visits	Pays same as other conditions	Includes dependent child maternity coverage. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Pre-certification required after 48 hours following vaginal delivery or 96 hours following c-section. Covered expenses will be reduced by 50% up to $500 if not obtained.
	Childbirth/delivery professional services	Pays same as other conditions	
	Childbirth/delivery facility services	Pays same as other conditions	

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	$30 copayment	Precertification required. Covered expenses will be reduced by 50% up to $500 if not obtained.
	Rehabilitation services	$30 copayment	62 visits per calendar year combined for occupational therapy, speech therapy, physical therapy and chiropractic care.
	Habilitation services	$30 copayment	
	Skilled nursing care	$100 copayment per day, up to $1,000 per admission	60 days per calendar year. Pre-certification required for services. Covered expenses will be reduced by 50% up to $500 if not obtained.
	Durable medical equipment	$50 copayment	None.
	Hospice services	$30 copayment for outpatient; $250 copayment for inpatient (up to $750 per admission)	Must have a life expectancy of 12 months or less. Pre-certification required for inpatient services. Covered expenses will be reduced by 50% up to $500 if not obtained.
If your child needs dental or eye care	Children's eye exam	No charge, up to age 19	If included in preventive care recommendations, to age 19
	Children's glasses	Not covered	Separate vision coverage available
	Children's dental check-up	Not covered	Separate dental coverage available

*Please see the plan for additional services that require pre-certification.

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.)

- Acupuncture
- Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances
- Cosmetic surgery, unless otherwise listed in plan as covered
- Dental care (Adult), unless otherwise listed in plan as covered
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing when outpatient. Inpatient and in the home services are covered
- Routine eye care (Adult)
- Routine foot care, unless otherwise listed in plan as covered
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric surgery	• Chiropractic care (limited to 62 visits per calendar year combined with occupational, speech and physical therapies)

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 Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-866-267-2323 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. 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: Custom Design Benefits 1-800-598-2929 or www.customdesignbenefits.com. Additionally, a consumer assistance program may be available in your state to help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and at http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 1-800-862-6704.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-862-6704.

Chinese (中文): **如果需要中文的帮助**，请拨打这个号码1-800-862-6704.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-862-6704.

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** **$0**
- **Specialist copayment** **$60**
- **Hospital (facility) copayment** **$250**
- **Coinsurance** **0%**

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	N/A
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$600
The total Peg would pay is	**$1,000**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$60**
- **Hospital (facility) copayment** **$250**
- **Coinsurance** **0%**

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	N/A
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,900**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$60**
- **Hospital (facility) copayment** **$250**
- **Coinsurance** **0%**

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	N/A
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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