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: Call 1-800-228-1803 or visit us at mybenefits.maestrohealth.com. 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.healthcare.gov/sbc-glossary or call 1-800-228-1803 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	No overall deductible	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes, Preventive services	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?	**Medical Out-of-Pocket:** **Emp. Only:** $**2,400** Network, $**4,800** Non-Network; **Emp. plus Spouse:** $**3,960** Network, $**7,920** Non-Network, **Emp. plus child(ren):** $**4,800** Network, $**9,600** Non-Network, **Emp. plus Family:** $**6,000** Network, $**12,000** Non-Network **Prescription Drug Out-of-Pocket:** **Emp. Only: $1,000** **Emp. Plus Spouse: $2,000** **Emp. Plus Child: $3,000** **Emp. Plus Family: $4,000**	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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

What is not included in the out-of-pocket limit?	Precertification program penalties, charges in excess of allowable expenses, premiums, balance-billed 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. Medcost PPO Network at www.medcost.com or call 1-800-824-7406 Maestro Health at mybenefits.maestrohealth.com or call 1-800-228-1803	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
		PPO Provider (You will pay the least)	Non-PPO 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	No charge for Everside Health 20% coinsurance for other providers	40% coinsurance	Members must utilize Everside Health providers and will have access to OB/ GYN, Mental Nervous and Pediatric providers outside of Everside Health.
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventative. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 800-933-3734 or www.pharmavail.com.	Generic drugs	No charge	No charge	Covers up to a 30-day supply (retail prescription); 90-day supply (mail-order prescription) If generic is available and employee receives brand name drug, the employee pays difference in cost. For drugs purchased through non-participating pharmacies, the reimbursement in excess of the amounts shown will be limited to the ingredient cost plus dispensing fee. **Prescription Drug Out-of-Pocket:** **Emp. Only: $1,000** **Emp. Plus Spouse: $2,000** **Emp. Plus Child: $3,000** **Emp. Plus Family: $4,000**
	Preferred brand drugs	**Retail Option** 20% coinsurance, minimum of $20; **Mail Order Option** 20% coinsurance, minimum of $60	**Retail Option** 20% coinsurance, minimum of $20; **Mail Order Option** 20% coinsurance, minimum of $60	
	Non-preferred brand drugs	**Retail Option** 40% coinsurance, minimum of $40; **Mail Order Option** 40% coinsurance, minimum of $120	**Retail Option** 40% coinsurance, minimum of $40; **Mail Order Option** 40% coinsurance, minimum of $120	
	Specialty drugs	**Retail Option** 40% coinsurance, minimum of $150; **Mail Order Option** 40% coinsurance, minimum of $450	**Retail Option** 40% coinsurance, minimum of $150; **Mail Order Option** 40% coinsurance, minimum of $450	Covers up to a 30-day supply (retail prescription); 90-day supply (mail-order prescription)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Non-Network benefits will apply to the Network Deductible and Maximum Out-of-Pocket.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at mybenefits.maestrohealth.com. .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for Paladina Health 20% coinsurance for other providers	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a [copayment, coinsurance, or deductible] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 60 visits per plan year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	Limited Benefits	Limited Benefits	See rehabilitation limitations.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days per plan year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$150 maximum/ plan year combined with glasses, hardware and contacts	$150 maximum/ plan year combined with glasses, hardware and contacts	An eye exam as a separate visit outside of pediatric preventive care is not covered.
	Children's glasses	$150 maximum/ plan year combined with eye exam	$150 maximum/ plan year combined with eye exam	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.)

- Acupuncture
- Bariatric surgery
- Chiropractic Care
- Cosmetic surgery
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine Foot care
- Weight loss program

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

- Dental Care (Adult)
- Long-term care
- Routine eye care (Adult)

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 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 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: Maestro Health at 1-800-228-1803 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and 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 1-800-228-1803.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-228-1803.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-228-1803.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-228-1803.

*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	N/A
Specialist coinsurance	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	$0
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,460**

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

The plan's overall deductible	N/A
Specialist coinsurance	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	$0
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

The plan's overall deductible	N/A
Specialist coinsurance	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	$0
Copayments	$0
Coinsurance	$600
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.