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, go to www.allwaysmember.org or call Customer Services at 1-866-567-9175 (toll free) or 711 (TTY). 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.allwayshealthpartners.org or call 1-866-567-9175 (toll free) or 711 (TTY) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** Individual, **$1,000** Family per benefit period. For outpatient surgery, inpatient care and emergency services, this plan requires a copayment to be paid prior to the deductible.	Generally, you must pay a copayment and then costs up to the deductible to providers for most services with a deductible. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible has been met.
Are there services covered before you meet your deductible?	Yes. Preventive care, most outpatient visits (including mental/behavioral health and substance use disorder), and urgent care does not apply towards the **deductible**.	This plan covers some items and services even if you haven't met the annual 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 www.allwayshealthpartners.org.
Are there other deductibles for specific services?	Yes. $100 Individual, $200 Family for prescription drugs per benefit period. Prescription drug coverage is administered through Express Scripts.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use.
What is the out-of-pocket limit for this plan?	**$5,000** Individual/**$10,000** Family per benefit period.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If family members in this plan, they have to meet their own out-of-pocket limits until family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums 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. For a list of **in-network providers**, see www.allwayshealthpartners.org or call 1-866-567-9175.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. 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?	Yes, you need a written or oral referral to see a specialist.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

Copayments and coinsurance costs shown in this chart are either before or 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	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment/visit	Not covered	---none---
	Specialist visit	Tier 1: $30, Tier 2: $60	Not covered	---none---
	Preventive care/screening/ immunization	No charge	Not covered	Services for specific conditions during an annual exam may be subject to cost sharing.
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	$100 copay, then subject to deductible	Not covered	May require prior authorization. Maximum of one copay per day.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider	Out-of-network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available through Express Scripts at *www.express-scripts.com/gicrx*	Generic drugs	Retail: $10 copay after deductible Maintenance 90/Mail Order: $25 copay after deductible	Not covered	Prescription drug coverage is administered by Express Scripts. For additional information, visit www.express-scripts.com/gicrx or call Customer Service at 1-855-283-7679 (TTY 711). Retail cost share is for up to a 30-day supply; mail order cost share is for up to a 90-day supply. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. A 90-day supply of maintenance medications may be obtained at a CVS Pharmacy for the applicable mail order copay. If a drug has a generic equivalent, and you buy the brand name (even if your physician indicates no substitutions), you will pay the generic-level copay plus the cost difference between the generic and the brand name drug.
	Preferred brand drugs	Retail: $30 copay after deductible Maintenance 90/Mail Order: $75 copay after deductible	Not covered	
	Non-preferred brand drugs	Retail: $65 copay after deductible Maintenance 90/Mail Order: $165 copay after deductible	Not covered	
	Specialty drugs	Limited to a 30-day supply with appropriate tier copay (see above) when purchased at a designated specialty pharmacy	Not covered	Must be obtained at a designated specialty pharmacy. Some drugs require prior authorization to be covered. Some drugs have quantity limitations. Some specialty drugs may also be covered under your medical benefit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider	Out-of-network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center (ASC))	$250 copay per occurrence, then subject to deductible For non-preventive colonoscopies, endoscopies, and eye surgeries, at: Free-standing/ASC: $150 per occurrence, then subject to deductible Hospital-based: $250 per occurrence, then subject to deductible	Not covered	Maximum of four outpatient copays apply per benefit period. May require prior authorization. Includes emergency dental surgery.
	Physician/surgeon fees	No charge	Not covered	---none---
If you need immediate medical attention	Emergency room services	$100 copay per occurrence, then subject to deductible		Emergency room copay waived if admitted to hospital for inpatient care. Includes emergency dental care.
	Emergency medical transportation	No charge after deductible		---none---
	Urgent care	$20 copay/visit		Copay same as copay for primary care provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	$275 copay per admission, then subject to deductible	Not covered	Maximum one inpatient copay per quarter, four per benefit period. May require prior authorization. Includes inpatient dental care.
	Physician/surgeon fee	No charge	Not covered	---none---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider	Out-of-network Provider	
If you need mental health, behavioral health, or substance use services	Mental/behavioral health/substance use outpatient services	$20 copay/visit	Not covered	---none---
	Mental/behavioral health/substance use inpatient services	No charge	Not covered	May require prior authorization.
If you are pregnant	Office visits for prenatal and postnatal care	No charge for routine prenatal and postnatal care	Not covered	---none---
	Childbirth/delivery facility services	$275 copay, then subject to deductible	Not covered	Maximum one inpatient copay per quarter, four per benefit period. May require prior authorization.
	Childbirth/delivery professional services	No charge	Not covered	May require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider	Out-of-network Provider	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	May require prior authorization.
	Rehabilitation services	**Outpatient:** $35 copay/visit **Inpatient:** $275 copay then subject to deductible per admission Maximum one inpatient copay per quarter, four per benefit period.	Not covered	**Outpatient:** Covered up to 90 consecutive days per condition for Physical Therapy/Occupational Therapy. **Inpatient**: Covered up to 60 days per benefit period. Prior authorization required.
	Habilitation services	**Outpatient:** $35 copay/visit **Inpatient:** $275 copay then subject to deductible per admission Maximum one inpatient copay per quarter, four per benefit period.	Not covered	**Outpatient:** Covered up to 90 consecutive days per condition for Physical Therapy/Occupational Therapy. **Inpatient**: Covered up to 60 days per benefit period. Prior authorization required. Cost and coverage limits are waived for early intervention services for eligible children.
	Skilled nursing care	No charge after deductible Maximum one inpatient copay per quarter, four per benefit period.	Not covered	Covered up to 100 days per benefit period. May require prior authorization.
	Durable medical equipment	No charge after deductible	Not covered	May require prior authorization. No charge for electric breast pump (one per birth).
	Hospice service	No charge	Not covered	May require prior authorization.
If your child needs dental or eye care	Children's eye exam	Tier 1: $30, Tier 2: $60	Not covered	One eye exam every 24 months for each child covered under this plan.
	Children's glasses	Not covered	Not covered	---none---
	Children's dental check-up	Not covered	Not covered	Limited to children under age 18 with a cleft palate/lip condition. You may have coverage under a separate dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Extraction of infected or impacted wisdom teeth (except when in a hospital setting)
- Long-term care
- Private-duty nursing
- Non-emergency care when traveling outside the U.S.
- Weight loss programs (except approved medically supervised programs)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Abortion
- Bariatric surgery
- Chiropractic care (up to 20 visits)
- Hearing aids (see handbook for limitations)
- Infertility treatment
- Routine eye exam (adult)
- Routine foot care (covered for diabetes and some circulatory diseases)

Your Grievance and Appeals Rights:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies are: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 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.

Your Rights to Continue Coverage:

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: Customer Service at **1-866-567-9175 (toll free) or 711 (TTY)**.

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 Standard? 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:

Para obtener asistencia en Español, llame al **1-866-567-9175.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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 with **Tier 2** specialist)

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$60**
- **Hospital (facility)** **$275 copayment then deductible**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$510
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$920**

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

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$60**
- **Hospital (facility)** **$275 copayment then deductible**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$230
Copayments	$1,430
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,660**

Mia's Simple Fracture
(in-network emergency room visit and follow up care with **Tier 2** specialist)

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$60**
- **Hospital (facility)** **$275 copayment then deductible**

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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$620
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,120**

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

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