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, www.myLuminareHealth.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 https://www.healthcare.gov/sbc-glossary or call 1-877-498-8937 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Preferred provider: $500/individual or $1,000/family. Nonpreferred provider: $2,000/individual or $4,000/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. The following services from a preferred provider: Preventive care, primary care and specialist services, emergency room care and urgent care services, rehabilitation services and habilitation services are covered before you meet your deductible.	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?	Preferred provider: $3,500/individual or $7,000/family. Nonpreferred provider: $10,000/individual or $20,000/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, 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?	Copays (including prescription drug copays), deductibles, pre-certification 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, for professional provider. See www.multiplan.com or call 1-877-952-7427 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).
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
		Preferred Provider (You will pay the least)	Nonpreferred 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	$25 copay/visit (deductible does not apply)	50% coinsurance	None
	Specialist visit	$40 copay/visit (deductible does not apply)	50% coinsurance	None
	Preventive care/screening/ immunization	No charge (deductible does not apply)	50% coinsurance	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)	5% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	5% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	10% coinsurance, $5 min, $20 max (retail 30-day) 10% coinsurance, $15 min, $60 max (retail 90-day) 10% coinsurance, $10 min, $40 max (mail order)		*Covers up to a 30-day supply (retail prescription or Specialty drugs); 90 day supply (retail or mail order prescription). *Prior Authorization / Coverage Management programs may apply to some drugs. *If a covered person chooses a preferred or non-preferred drug rather than the generic equivalent when the physician allowed a generic drug to be dispensed, the covered person will be responsible for the cost difference between the generic and preferred or non-preferred drug in addition to the preferred or non-preferred drug copay. The covered person's share of the prescription drug does not apply toward the prescription plan's out-of-pocket maximum.
	Preferred brand drugs	20% coinsurance, $20 min, $40 max (retail 30-day) 20% coinsurance, $60 min, $120 max (retail 90-day) 20% coinsurance, $40 min, $80 max (mail order)		
	Non-preferred brand drugs	35% coinsurance, $45 min, $90 max (retail 30-day) 35% coinsurance, $135 min, $270 max (retail 90-day) 35% coinsurance, $90 min, $180 max (mail order)		
	Specialty drugs	20% with $150 maximum		

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	Not applicable	Pre-certification is required for some outpatient procedures. A $250 penalty will be imposed for failure to pre-certify benefits.
	Physician/surgeon fees	5% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay/visit, plus 5% coinsurance (deductible does not apply)	Preferred provider benefit applies.	Copay waived if admitted.
	Emergency medical transportation	5% coinsurance	Preferred provider benefit applies.	None
	Urgent care	$100 copay/visit (deductible does not apply)	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	Not applicable	Pre-certification is required. A $250 penalty will be imposed for failure to pre-certify benefits.
	Physician/surgeon fees	5% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit (deductible does not apply)	50% coinsurance	None
	Inpatient services	5% coinsurance	50% coinsurance	Pre-certification is required. A $250 penalty will be imposed for failure to pre-certify benefits.
If you are pregnant	Office visits	$25 copay/visit (deductible does not apply) Subsequent visits: 5% coinsurance	50% 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	5% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	5% coinsurance	Not applicable	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	5% coinsurance	50% coinsurance	Limited to 100 visits per benefit period. Pre-certification is required. A $250 penalty will be imposed for failure to pre-certify benefits.
	Rehabilitation services	$25 copay/visit (deductible does not apply)	50% coinsurance	Limited to 30 visits combined per benefit period for speech, occupational and hearing therapy. Limited to 60 visits per benefit period for physical therapy. Copay waived for occupational and physical therapy if services are rendered at a VibrantCare Rehabilitation facility for non-work related illness or injury.
	Habilitation services	$25 copay/visit (deductible does not apply)	50% coinsurance	
	Skilled nursing care	5% coinsurance	50% coinsurance	Limited to 100 visits per benefit period. Pre-certification is required. A $250 penalty will be imposed for failure to pre-certify benefits.
	Durable medical equipment	5% coinsurance	50% coinsurance	None
	Hospice services	5% coinsurance	50% coinsurance	Pre-certification is required. A $250 penalty will be imposed for failure to pre-certify benefits.
If your child needs dental or eye care	Children's eye exam	100% up to $60 max	100% up to $60 max	Limited to 1 exam every 12 months.
	Children's glasses	100% up to $160 max	100% up to $160 max	Limited to 1 pair of lenses, frames, or contact lenses every 12 months.
	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
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care for Non-Diabetics
- Weight loss programs

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

- Non-emergency care when traveling outside the U.S.
- Routine eye care

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-EBSA (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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-877-498-8937.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-877-498-8937.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-498-8937.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-877-498-8937 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-498-8937.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-498-8937.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-498-8937.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-877-498-8937.

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	**$500**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**5%**
Other coinsurance	**5%**

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	$500
Copayments	$10
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,170**

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

The plan's overall deductible	**$500**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**5%**
Other coinsurance	**5%**

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	$500
Copayments	$1,600
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,140**

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

The plan's overall deductible	**$500**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**5%**
Other coinsurance	**5%**

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	$500
Copayments	$500
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,060**

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