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, contact Group Administrators, Ltd. at www.groupadministrators.com or call 1-800-323-1683. 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.groupadministrators.com or call 1-800-323-1683 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$5,000** individual / **$10,000** family Copayments do not apply to the deductible.	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. Preventive care, primary care services, specialist visits and prescriptions 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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,350/Covered Person or $14,700/Family; (includes all copays and coinsurance)	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?	Cost Containment penalties, 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?	Not Applicable.	This plan does not use a provider network. 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.

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 (You will pay the least)	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	$25 copay/office visit; deductible does not apply to the office visit charge	Deductible Waived
	Specialist visit	$25 copay/office visit; deductible does not apply to the office visit charge	Deductible Waived
	Preventive care/screening/ immunization	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	*Hospital Services:* 30% coinsurance, ; after deductible *Physician's Office & Independent Lab:* $50 copay *Physician's Radiology:* $100 copay	Certain genetic tests and high-technology imaging require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Imaging (CT/PET scans, MRIs)	Outpatient: $100 copay In-Patient : 30% coinsurance,; after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.truescripts.com	Generic drugs (Tier 1)	$10 copay/prescription (retail) & $20 copay/prescription (home delivery)	Covers up to a 30-day supply retail/90-day supply home delivery. If brand dispensed when generic available, you are responsible for dollar amount difference between brand and generic. Drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Preferred brand drugs (Tier 2)	$35 copay/prescription (retail) & $70 copay/prescription (home delivery)	
	Non-preferred brand drugs (Tier 3)	$65 copay/prescription (retail) & $130 copay/prescription (home delivery)	
	Specialty Drugs (Tier 4)	Specialty Drugs are not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$25 copay then 30% coinsurance	Deductible waived; Prior Authorization is required

Common Medical Event	Services You May Need	What You Will Pay (You will pay the least)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	$25 copay then 30% coinsurance	Deductible waived; Prior Authorization is required
If you need immediate medical attention	Emergency room care	$500 copay per visit; then 30% coinsurance	None
	Emergency medical transportation	30% coinsurance	Deductible Applies
	Urgent care	$75 copay/office visit; deductible does not apply	Deductible Waived
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Deductible Applies; Prior Authorization is required; Inpatient Rehab Services limited to 30 days
	Physician/surgeon fees	30% coinsurance	Deductible Applies; Prior Authorization is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit ; deductible does not apply to the office visit charge	Deductible Waived for office visit; Prior Authorization is required Partial Hospitalization
	Inpatient services	30% coinsurance	
If you are pregnant	Office Visits	No charge; deductible does not apply to the office visit charge	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). All non- emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Childbirth/delivery professional services	30% coinsurance	Deductible Applies
	Childbirth/delivery facility services	30% coinsurance	Deductible Applies
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Deductible Applies; 60 Maximum visits per plan year; Prior Authorization is required (Limit not applicable to mental health and substance abuse)
	Rehabilitation services	$25 copay/office visit; deductible does not apply to the office visit charge	Coverage limited to 20 visits per category, including 25 manipulations. Services performed in hospital may have higher cost share.
	Habilitation services	Not Covered	Not Covered

Common Medical Event	Services You May Need	What You Will Pay (You will pay the least)	Limitations, Exceptions, & Other Important Information
	Skilled nursing care	30% coinsurance	Skilled Nursing is limited to 60 days per calendar year (combined with Inpatient Rehabilitation)
	Durable medical equipment	30% coinsurance	Deductible Applies; Prior authorization is required for DME in excess of $1,000
	Hospice services	30% coinsurance	Deductible Applies
If your child needs dental or eye care	Children's eye exam	Not Covered	None
	Children's glasses	Not covered	None
	Children's dental check-up	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.)

- Bariatric Surgery
- Cosmetic Surgery
- Acupuncture
- Habilitation Services
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Pediatric Eye Exam
- Private Duty Nursing
- Glasses
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care – 25 Visits
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.

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: your state insurance department, the 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 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 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: Group Administrators, Ltd at 1-800-323-1683.

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 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 1-800-323-1683.

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 pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$5,000**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	$5,000
Copayments	$0
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$4,710**

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

- **The plan's overall deductible** **$5,000**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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*	$400
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,130**

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

- **The plan's overall deductible** **$5,000**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$100
Copayments	$500
Coinsurance	$320
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$920**

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