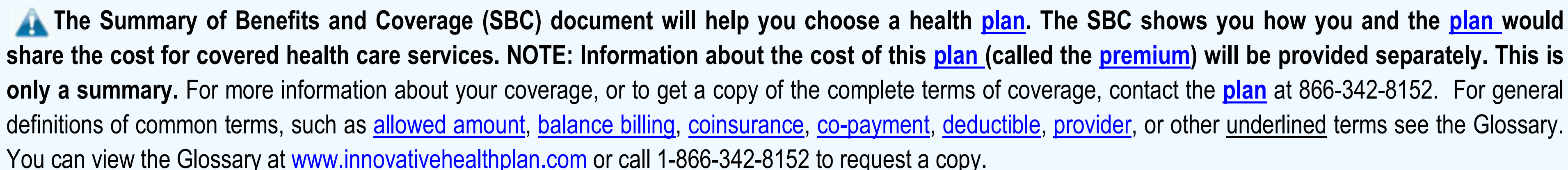


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the **plan** at 866-342-8152. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.innovativehealthplan.com or call 1-866-342-8152 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$750 individual / $2,000 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. Preventive care and Contraceptive Management 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 co-payment 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$7,900 individual / $15,800 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?	Non-covered expenses including but not limited to charges that exceed RBR – Referenced Based Reimbursement.	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 MultiPlan www.innovativehealthplan.com or call 1.866.342.8152 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). 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 do not need a referral to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services.

All co-payment 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay / visit	None
	Specialist visit	$40 co-pay / visit	
	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 – in a Physician office or free standing non-hospital billed facility	Diagnostic test (x-ray, blood work)	$10 co-pay	None
	Imaging (CT/PET scans, MRIs)	$250 co-pay	
If you have a test – in a Hospital billed facility	Diagnostic test (x-ray, blood work)	$25 co-pay	None
	Imaging (CT/PET scans, MRIs)	$500 co-pay	
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 Non-Maintenance Retail Maintenance Mail Order Maintenance Retail	 $9 or less co-pay $18 or less co-pay $18/$54 or less co-pay	Non-Maintenance Retail – up to 30 days Maintenance Mail Order – up to 90 days Maintenance Retail – 30/90 day supply after 2nd fill
	Brand drugs (Preferred/Non-Preferred) Non-Maintenance Retail Maintenance Mail Order Maintenance Retail	 30% up to $300 maximum per prescription 30% X 2 up to $600 maximum per prescription 50% up to $300/$900 maximum per prescription	
	Specialty drugs	40% up to maximum of $300/$900 per	30/90 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 co-pay after deductible	Deductible must be met
	Physician/surgeon fees	$40 co-pay	None
If you need immediate medical attention	Emergency room care	$250 co-pay/visit	Co-pay waived if admitted
	Emergency medical transportation	No charge	None
	Urgent care	$50 co-pay/visit	None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility Fee (e.g., hospital room)	$500 co-pay after deductible	Deductible must be met
	Physician/surgeon fees		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 co-pay	None
	Inpatient services	$500 co-pay after deductible	Deductible must be met
If you are pregnant	Office visits	No charge	None
	Childbirth/delivery professional services	$500 co-pay after deductible	Deductible must be met
	Childbirth/delivery facility services		
If you need help recovering or have other special needs	Home health care	100% after deductible	Deductible must be met 80 visits per calendar year
	Rehabilitation services Habilitation services	$45 co-pay/visit	Outpatient Therapy – Occupational, Physical & Speech 30 visits per calendar year per therapy.
	Skilled nursing center	$250 co-pay	60 days per calendar year
	Durable medical equipment	30% coinsurance	None
	Hospice services	Inpatient - $500 co-pay/visit after deductible Outpatient – No charge	Deductible must be met (Inpatient)
If your child needs dental or eye care	Children's eye exam	No charge	None
	Children's glasses	Benefits required as provided by PPACA	
	Children's dental checkups		

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.)		
• Services & Supplies Not Medically Necessary • Plastic or cosmetic surgery, unless for reconstruction caused by a covered injury or mastectomy • Non-emergency care when traveling outside the U.S.	• Acupuncture • Bariatric Surgery • Custodial Care • Any drug, device, medical treatment or procedure that is experimental/investigative	• Services/supplies rendered to treat hair loss or to promote hair growth • Reversal of sterilization • Sex change operation or complications from that surgery • Infertility Treatment
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Allergy injections; testing; serum • Birthing Center • Contraceptive management • Chiropractic treatment	• Infertility Diagnostics • Manipulative therapy • Newborn coverage (if Dependent is enrolled within 31 days of child's birth) • Organ Transplant benefits	• Orthotics • Private Duty Nursing • Prosthetic Devices • Skilled Nursing Facility

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 the 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: www.innovativehealthplan.com or call 1-866-342-8152.

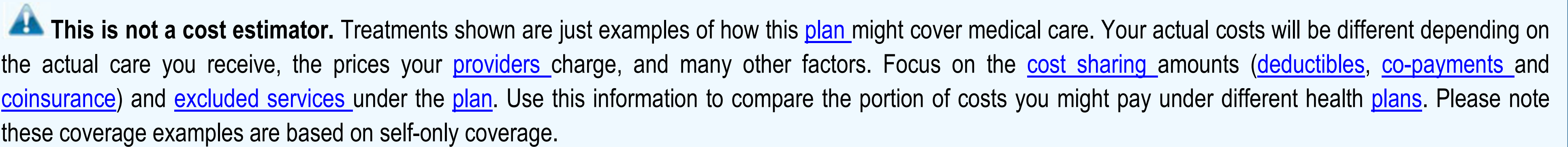
Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum 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.

Note regarding 'Your Cost If You Use an Out-of-network Provider'- For Physicians and Ancillary Providers Only:
Network Providers have agreed to accept the Usual and Customary Charges (UCR) as payment in full. However, when you receive services from Non-Network Providers, you are responsible for any amounts over the Medicare-based reimbursement levels. Non-Network Providers may charge considerably higher amounts. Therefore, if the billed amount exceeds the Medicare-based allowable charge, your provider may bill you for the difference. It is best to utilize network providers whenever possible. These amounts are Allowed Charges, while the responsibility of the Covered Person, do not apply toward deductible or out-of-pocket maximums. Please refer to your Summary Plan Description (SPD) for details.

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, co-payments 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 $750
- Specialist co-payment $40
- Hospital (facility) [cost sharing] 0%
- Other 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	$750
Co-payments	$559
Coinsurance	$0
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$1,370**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible $750
- Specialist co-payment $40
- Hospital (facility) [cost sharing] 0%
- Other 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	$750
Co-payments	$113
Coinsurance	$237
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$1,122**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible $750
- Specialist co-payment $40
- Hospital (facility) [cost sharing] 0%
- Other 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	$0
Co-payments	$369
Coinsurance	$75
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$444**

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