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 (800) 649-9121. 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.cciio.cms.gov or call 1-800-649-9121 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$ 0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	Not Applicable.
Are there other deductibles for specific services?	No.	Not Applicable.
What is the out-of-pocket limit for this plan?	Yes. **Network: $ 2,000 /** person, **$ 4,000 /** 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover. Non-compliance penalties for pre-authorization.	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. See www.pinnacletpa.com or call **1-800-649-9121**.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 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
		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	$25 copay / visit.	Not covered	Includes related in-office services
	Specialist visit	$25 copay / visit.	Not covered	Includes related in-office services
	Preventive care/screening/ immunization	No charge	Not covered	Recommended frequency based on Federally-required guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Retail 30-days: www.prxsolutions.com Retail 90-days: www.informedrx.com Mail Order: www.myWDRX.com Specialty Rx: www.acariahealth.com	Generic drugs (Tier 1)	Retail: $10 copay / prescription/30 days. Retail: $30 copay / prescription/90 days. Mail Order: $20 copay / prescription/90 days.	Not covered	Supply Limits Retail: 30-day supply. Retail: 90-day supply. Mail Order: 90-day supply.
	Preferred brand drugs (Tier 2)	Retail: $30 copay / prescription/30 days. Retail: $90 copay / prescription/90 days. Mail Order: $60 copay / prescription/90 days.	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: $50 copay / prescription/30 days. Retail: $150 copay / prescription/90 days. Mail Order: $100 copay / prescription/90 days.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
	Specialty drugs (Tier 4)	Generic: $10 copay / prescription. Preferred: $30 copay / prescription. Non-preferred: $50 copay / prescription.	Not covered	Mail Order: 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Pre-authorization required or 50% reduction in benefits.
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$150 copay / occurrence		Copay waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	To or from nearest Hospital, home or Skilled Nursing Facility.
	Urgent care	$25 copay / visit	Not covered	Copay waived if admitted to Hospital.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay + 10% coinsurance / occurrence	Not covered	Pre-authorization required or 50% reduction in benefits.
	Physician/surgeon fees	10% coinsurance	Not covered	Pre-authorization required or 50% reduction in benefits.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay / visit	Not covered	Office visit only
	Inpatient services	10% coinsurance	Not covered	Pre-authorization required or 50% reduction in benefits
If you are pregnant	Office visits	$25 copay / visit	Not covered	Cost sharing does not apply to certain preventive services.
	Childbirth/delivery professional services	10% coinsurance	Not covered	No prior authorization is required for 48 hours following a vaginal delivery and 96 hours following a cesarean delivery. If exceeds those hours, then a prior authorization is required for mother and newborn or no further benefit.
	Childbirth/delivery facility services	10% coinsurance		
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Maximum: 100 visits / plan year
	Rehabilitation services	10% coinsurance	Not covered	Maximum: 26 visits / plan year
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	10% coinsurance	Not covered	Maximum: 100 visits / plan year

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider	
	Durable medical equipment	10% coinsurance	Not covered	Pre-authorization recommended. Rental or purchase subject to approval, costs not to exceed the purchase price. Durable medical equipment and supplies must be purchased from a Network provider.
	Hospice services	10% coinsurance. $25 copay / visit for bereavement counseling.	Not covered	Bereavement counseling limited to 8 visits for 6 months after death of Covered Person.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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.)

- Cosmetic surgery
- Dental care
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S. (except Mexico Panel)
- Non-Network Services
- Private Duty Nursing
- Routine foot care (unless Medically Necessary)
- Routine eye care
- Weight loss programs
- Bariatric surgery (Medically Necessary)

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

- Acupuncture
- Chiropractic care
- Infertility treatment

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 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: Pinnacle Claims Management, Inc. at 1-800-649-9121.

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 1-800-649-9121.

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	$ 0
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$340
Coinsurance	$1,140
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,540**

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

The plan's overall deductible	$ 0
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$890
Coinsurance	$170
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,120**

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

The plan's overall deductible	$ 0
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$140
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$340**

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