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 253-925-0500. 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.dol.gov/ebsa/healthreform or call 253-925-0500 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 person/$4,000 family for Preferred Network. $2,000 person/$4,000 family for Participating Network. $4,000 person/$8,000 family for Out-of-Network	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. Breast pumps, flu shots, immunizations and urgent care for all Networks. All preventive care & services for Preferred & Participating Networks. Office visits to a primary care provider or specialist, outpatient mental health services, naturopathic services & outpatient substance use disorder services and injections for Preferred Network.	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?	$4,500 person/$9,000 family for Preferred & Participating Networks combined. $9,000 person/$18,000 family for Out-of-Network. $1,000 person/$2,000 person for Preferred and Participating Pharmacy. Unlimited for Out-of-Network.	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?	Out-of-Network copays, penalties, ineligible charges, premiums, balance-billed 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. See www.accesshma.com or call 1-800-700-7153 for a list of network providers.	You pay the least if you use a provider in the Preferred Network. You pay more if you use a provider in the Participating 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 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)	Participating Provider	Out-of-Network 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	$35/visit, deductible does not apply	$35/visit, then 50% coinsurance	$35/visit, then 50% coinsurance	Includes Family Practice, Pediatrics, General Medicine, Internal Medicine, Doctor of Osteopathic Medicine, Nurse Midwife, Nurse Practitioner, Physician's Assistant and OB/GYN.
	Specialist visit	$50/visit, deductible does not apply	$50/visit, then 50% coinsurance	$50/visit, then 50% coinsurance	----------none----------
	Preventive care/screening/ immunization	No charge, deductible does not apply	No charge, deductible does not apply	Not covered	Out-of-Network breast pumps, flu shots and immunizations are covered at no charge, deductible does not apply. Out-of-Network contraceptive services are covered at 50% coinsurance after a $35 copay. Out-of-Network dietary education, tobacco cessation and sterilization are covered at 50% coinsurance. Tobacco cessation is limited to 8 visits per calendar year. 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)	20% coinsurance			----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance			----------none----------
	Generic drugs	$15 copay for retail; $30 copay for mail order			Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	$35 copay for retail; $70 copay for mail order			
	Non-preferred brand drugs	$70 copay for retail; $140 copay for mail order			

ut limitations and exceptions, see the plan or policy document at www.badenbenefits.com (username: baden, password: benefits).]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Specialty drugs	20% coinsurance up to $150			Please contact Caremark, your specialty pharmacy, for more information on what is covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	50% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	50% coinsurance	50% coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	$250/visit, then 20% coinsurance			Copay waived if admitted as an inpatient or accident related and services are received within 2 days from the date of the accident.
	Emergency medical transportation	20% coinsurance			----------none----------
	Urgent care	$60/visit, deductible does not apply			----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	50% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	50% coinsurance	50% coinsurance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35/visit, deductible does not apply	$35/visit, then 50% coinsurance	$35/visit, then 50% coinsurance	Family, marital, and sexual counseling are not covered.
	Inpatient services	20% coinsurance	50% coinsurance	50% coinsurance	Preauthorization is required. Residential treatment is covered.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	50% coinsurance	----------none----------
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	50% coinsurance	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be preauthorized at the time your provider recommends the extended stay.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance			Preauthorization is required. Limited to a 90-visit calendar year maximum.
	Rehabilitation services	20% coinsurance	50% coinsurance	50% coinsurance	Preauthorization is required for inpatient and is limited to a 60-day calendar year maximum. Swim therapy is not covered.
	Habilitation services	Not covered			Neurodevelopmental therapy is covered under outpatient rehabilitation with no age limit.
	Skilled nursing care	20% coinsurance			Preauthorization is required. Limited to a 120-day calendar year maximum.
	Durable medical equipment	20% coinsurance	50% coinsurance	50% coinsurance	Preauthorization is required for equipment over $2,000.
	Hospice services	20% coinsurance			Preauthorization is required. Limited to a 6-month lifetime maximum.
If your child needs dental or eye care	Children's eye exam	Not included with Medical			If enrolled, please refer to your plan document.
	Children's glasses	Not included with Medical			If enrolled, please refer to your plan document.
	Children's dental check-up	Not included with Medical			If enrolled, please refer to your plan document.

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
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Family, marital and sexual counseling
- Hearing aids
- Habilitation Services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)
- Routine foot care (except diabetes)
- Swim therapy
- 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 (12-visit yearly limit)
- Private-duty nursing (transplants only)

[* For more information about limitations and exceptions, see the plan or policy document at www.badenbenefits.com (username: baden, password: benefits).]

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 HMA COBRA team, 1-800-700-7153, and 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 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: 1-800-700-7153, and the 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
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 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 1-800-700-7153.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-700-7153.]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-700-7153.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-700-7153.]

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	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$12,720

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$20
Coinsurance	$1,720
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,800

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$7,270

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,790
Copayments	$810
Coinsurance	$00
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,660

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,930

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,480
Copayments	$300
Coinsurance	$00
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,780

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