




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 (206) 505-9500. 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 (206) 505-9500 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>\$1,000 person / \$3,000 family for Preferred Network. There is no <u>deductible</u> limit for Participating & Out-of-Network.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. ABA therapy, breast pumps, chemical dependency outpatient professional, Cologuard medical & preventive, flu shots, gene therapy travel, hearing aids & exams, immunizations, massage therapy, medical travel for steerage, mental nervous outpatient professional, transplant expenses (travel, meals, lodging) and urgent care facility for all Networks. Mammograms medical, preventive care & services for Preferred & Participating Networks. Allergy injections, genetic testing, outpatient office visits & services and laboratory for Preferred Network.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No. There are no other specific <u>deductibles</u>.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>\$3,600 person / \$10,800 family for Preferred Network. There is no Out-of-pocket limit for Participating & Out-of-Network. Includes pharmacy.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Penalties, ineligible charges, premiums, balance-billed charges and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.accessrga.com or call 1-866-738-3924 for a list of network providers.</p>	<p>You pay the least if you use a <u>provider</u> in the Preferred Network. You pay more if you use a <u>provider</u> in the Participating Network. You will pay</p>

		the most if you use an <u>out-of-network provider</u> and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (balance billing). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 or Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25/visit, <u>deductible</u> does not apply	Not covered	—————none—————
	<u>Specialist</u> visit	\$50/visit, <u>deductible</u> does not apply	Not covered	—————none—————
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	Participating Network: No charge, <u>deductible</u> does not apply Out-of-Network: Not covered	Out-of-Network breast pumps, flu shots, immunizations covered at no charge, <u>deductible</u> does not apply. 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	<u>Diagnostic test</u> (x-ray, blood work)	20% coinsurance, <u>deductible</u> does not apply	Not covered	—————none—————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	—————none—————
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	\$10 copay for retail 30-day supply; \$20 copay for retail or mail order 90-day supply		Covers up to a 90-day supply (retail and mail order prescription). See plan document for non-use of generic drug penalty.
	Preferred brand drugs	\$35 copay for retail 30-day supply; \$70 copay for retail or mail order 90-day supply		
	Non-preferred brand drugs	\$70 copay for retail 30-day supply; \$140 copay for retail or mail order 90-day supply		
	<u>Specialty drugs</u>	\$110 copay for 30-day supply; \$220 copay for 90-day supply		

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating or Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100/visit, then 20% coinsurance	Not covered	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	Not covered	—————none—————
If you need immediate medical attention	Emergency room care	\$150/visit		<u>Copay</u> waived if admitted.
	Emergency medical transportation	20% coinsurance		—————none—————
	Urgent care	\$35/visit, <u>deductible</u> does not apply		—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200/visit per admit, then 20% coinsurance	Not covered	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	Not covered	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Facility: 20% coinsurance Professional: \$25/visit, <u>deductible</u> does not apply	Facility: Not covered Professional: \$25/visit, <u>deductible</u> does not apply	Preauthorization is required for partial hospitalization or intensive outpatient.
	Inpatient services	\$200/visit per admit, then 20% coinsurance	Not covered	Preauthorization is required. Residential treatment is covered.
If you are pregnant	Office visits	\$25/visit, <u>deductible</u> does not apply	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	Not covered	—————none—————
	Childbirth/delivery facility services	\$200/visit per admit, then 20% coinsurance	Not covered	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.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating or Out-of- Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Preauthorization is required. Limited to 130 visits per calendar year.
	Rehabilitation services	Inpatient: No charge Outpatient: \$50/visit, <u>deductible</u> does not apply	Not covered	Preauthorization is required for inpatient and limited to no maximum. Outpatient is limited to a 60-visit calendar year maximum, with an additional 30 visits for brain, spinal cord injuries or the treatment of a stroke. Swim therapy is not covered.
	Habilitation services	\$50/visit, <u>deductible</u> does not apply	Not covered	Habilitation services, including neurodevelopmental therapy and rehabilitative therapies for the treatment of autism, are covered under the Outpatient Rehabilitation Services benefit. Outpatient Rehabilitation Services visit limits do not apply
	Skilled nursing care	20% coinsurance	Not covered	Preauthorization is required. Limited to 120 day per calendar year maximum.
	Durable medical equipment	No charge	Not covered	Preauthorization is required for equipment over \$2,000.
	Hospice services	No charge	Not covered	Preauthorization is required.
	If your child needs dental or eye care	Children's eye exam	Not included	
Children's glasses		Not included		If enrolled, please refer to plan document.
Children's dental check-up		Not covered		Please contact dental benefit administrator.

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

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
- Dental care (Adult)
- Infertility treatment (except for testing)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (except if medically necessary)
- Weight loss programs

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

- Acupuncture (26 visits per calendar year)
- Chiropractic care (26 visits per calendar year)
- Hearing aids (\$3,000 maximum every 3 calendar years)
- Private-duty nursing (130-visit yearly limit)

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: Allegiance, 800-259-2738 ext. 4477, 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: 1-866-738-3924, 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**

[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 1-866-738-3924.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-738-3924.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-738-3924.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-738-3924.]

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](#) \$1,000
- [Specialist](#) copayment \$50
- Hospital (facility) copay, coins \$200, 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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$210
Coinsurance	\$1,990
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,260

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist](#) copayment \$50
- Hospital (facility) copay, coins \$200, 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$00
Copayments	\$710
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$750

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist](#) copayment \$50
- Hospital (facility) copay, coins \$200, 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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$400
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$00
The total Mia would pay is	\$1,420