**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, go to www.detegohealth.com or call 1-866-815-6001. 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.com or www.cciio.cms.gov

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 There is no **deductible.** | Generally, you must pay all 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 other deductibles for specific services?** | No. Preventive care services are covered before any out-of-pocket costs. | 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 |
| **What is the out-of-pocket limit for this plan?** | The Plan is a Minimum Essential Coverage (MEC) Plan and has no out-of-pocket limit for covered services. | 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 must 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?** | This Plan does not have an **out-of-Pocket limit.** | 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 | **The plans utilizes the First Health Network for covered services. To find a provider, visit docfind.health . There are NO out of network benefits available.** |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | See Plan Document for details |

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 |
|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 Per Visit | 4 Visits Per Year Subject to Plan Allowable |
| | Specialist visit | $50 Per Visit | 3 Visits Per Year Subject to Plan Allowable |
| | Preventive care/screening/ immunization | $0 Per Visit | 1 Visit Per Year (Maximum $150 Per Visit) Subject to Plan Allowable |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Not Covered | Self pay options: visit greenimaging.net or fairmarkethealth.com. |
| | Imaging (CT/PET scans, MRIs) | Not Covered | Self pay options: visit greenimaging.net or fairmarkethealth.com. |
| **If you need drugs to treat your illness or condition** | Generic Drugs | Available through MyLiveDoc | Formulary Only. Non-Covered prescriptions may be available through ScriptCo at a Self-Pay discounted cost. |
| | Preferred brand drugs & Specialty | Not Covered | Specialty & High-Cost Meds are available through PAP only. Note, PAP requires members to meet certain financial criteria |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) & Physician Surgery Fees | Not Covered | Some Outpatient Surgical services may be available at a self-pay rate through Fair Market Health. fairmarkethealth.com. |
| **If you need immediate medical attention** | Emergency room care | Not Covered | |
| | Emergency medical transportation | Not Covered | |
| | Urgent care | $75 Per visit | 2 Visits Per Year Subject to Plan Allowable |

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

| 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) | 2 Days covered per benefit period | Emergency Admits Only Elective Procedures, ICU and NICU not covered<br>Hospitalization (inpatient and outpatient) benefits are not payable for a Pre-Existing Condition for the first Twelve [12] Months of coverage. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Available through MyLiveDoc only | Subject to Plan Allowable |
| | Inpatient services | 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.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatments
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)**

**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: 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: Detego Health at 866-815-6001 or 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**

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

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 [866-815-6001]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [866-815-6001]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[866-815-6001]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [866-815-6001]

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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

## 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 *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **100%**
- **Other *[cost sharing]*** **100%**

**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** | **$8,000** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $8,000 |
| **The total Peg would pay is** | **$8,000** |

### 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 *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **100%**
- **Other *[cost sharing]*** **100%**

**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** | **$500** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $50 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $300 |
| **The total Joe would pay is** | **$350** |

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

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **100%**
- **Other *[cost sharing]*** **100%**

**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** | **$1,500** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $1500 |
| **The total Mia would pay is** | **$1500** |

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