



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 your Human Resources Department at 1-877-440-8256 or 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 <https://www.healthcare.gov/sbc-glossary> or call 1.800.742.9944 (Compliance Department) to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the over-all <a href="#">deductible</a> ?                               | \$0   | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes, Preventative Services are covered. See page 2  | See the Common Medical Events chart below for your costs for services this plan covers.   |
| Are there other <a href="#">deductible's</a> for a specific service?            | No.   | You don't have to meet <a href="#">deductibles</a> for a specific service.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Not Applicable.   | This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Not Applicable.   | This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.  |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes, for a list of providers for Multiplan, see: <a href="http://www.multiplan.com">www.multiplan.com</a> or call 800.922.4362. | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You pay the least if you use a <a href="#">provider</a> in the <a href="#">Network provider</a> tier. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">Network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.   | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |



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<br>(you will pay less)           | Non-Network Provider<br>(you will pay more) |  |
| If you visit a health care <a href="#">provider's</a> office or clinic  | Primary care visit to treat an injury or illness       | Not covered                                       | Not covered                                 | Only <a href="#">preventative care services</a> required by the Affordable Care Act (ACA) are covered. You may have to pay for services that aren't <a href="#">preventative</a> . Ask your <a href="#">provider</a> if the services are <a href="#">preventative</a> . For a list of ACA <a href="#">preventative care services</a> , visit <a href="https://www.hhs.gov/healthcare/about-the-aca/preventative-care/index.html">https://www.hhs.gov/healthcare/about-the-aca/preventative-care/index.html</a> |
|   | <a href="#">Specialist</a> visit                       | Not covered                                       | Not covered                                 |  |
|   | <a href="#">Preventive care/screening/immunization</a> | No charge to member                               | Not covered                                 |  |
| If you have a test  | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge to member for ACA preventative services | Not covered                                 | Only <a href="#">preventative care services</a> required by the Affordable Care Act (ACA) are covered. For a list of ACA <a href="#">preventative care services</a> , visit <a href="https://www.hhs.gov/healthcare/about-the-aca/preventative-care/index.html">https://www.hhs.gov/healthcare/about-the-aca/preventative-care/index.html</a>  |
|   | Imaging (CT/PET scans, MRIs)                           | Not covered                                       | Not covered                                 |  |
| If you need drugs to treat your illness or condition. More information about <a href="#">prescription drug coverage</a> is available at <a href="#">MedTrakRx</a> or call 1-800-771-4648. | Contraceptives   | No charge to member                               |   | For more information about <a href="#">prescription drug coverage</a> under the ACA, visit <a href="https://www.hhs.gov/healthcare/about-the-aca/preventative-care/index.html">https://www.hhs.gov/healthcare/about-the-aca/preventative-care/index.html</a>   |
|   | ACA Supplements/Drugs                                  | No charge to member                               |   |  |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)         | Not covered                                       | Not covered                                 |  |
|   | Physician/surgeon fees                                 | Not covered                                       | Not covered                                 |  |
| If you need immediate medical attention   | <a href="#">Emergency room care</a>                    | Not covered                                       | Not covered                                 |  |
|   | <a href="#">Emergency medical transportation</a>       | Not covered                                       | Not covered                                 |  |
|   | <a href="#">Urgent care</a>                            | Not covered                                       | Not covered                                 |  |

|  |   |             |             |   |
|--|---|-------------|-------------|---|
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)        | Not covered | Not covered |   |
|  | Physician/surgeon fees                    | Not covered | Not covered |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | Not covered | Not covered | Only <u>preventative care services</u> required by the Affordable Care Act (ACA) are covered. For a list of ACA <u>preventative care services</u> , visit <a href="https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html">https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html</a> |
|  | Inpatient services                        | Not covered | Not covered |   |
| <b>If you are pregnant</b>   | Office visits                             | Not covered | Not covered | Only <u>preventative care services</u> required by the Affordable Care Act (ACA) are covered. For a list of ACA <u>preventative care services</u> , visit <a href="https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html">https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html</a> |
|  | Childbirth/delivery professional services | Not covered | Not covered |   |
|  | Childbirth/delivery facility services     | Not covered | Not covered |   |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | Not covered | Not covered |   |
|  | <a href="#">Rehabilitation services</a>   | Not covered | Not covered |   |
|  | <a href="#">Habilitation services</a>     | Not covered | Not covered |   |
|  | <a href="#">Skilled nursing care</a>      | Not covered | Not covered |   |
|  | <a href="#">Durable medical equipment</a> | Not covered | Not covered |   |
|  | <a href="#">Hospice services</a>          | Not covered | Not covered |   |
| <b>If your child needs dental or eye care</b>                                    | Children's eye exam                       | Not covered | Not covered | Only <u>preventative care services</u> required by the Affordable Care Act (ACA) are covered. For a list of ACA <u>preventative care services</u> , visit <a href="https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html">https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html</a> |
|  | Children's glasses                        | Not covered | Not covered |   |
|  | Children's dental check-up                | 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](#).)

- |  |                         |                            |
|--|-------------------------|----------------------------|
| • Acupuncture  | • Bariatric surgery     | • Chiropractic care        |
| • Cosmetic surgery                                   | • Dental care (Adult)   | • Long-term care           |
| • Hearing aids                                       | • Infertility treatment | • Routine eye care (Adult) |
| • Non-emergency care when traveling outside the U.S. | • Private-duty nursing  |                            |
| • 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.)

- Only [preventative care services](#) required by the Affordable Care Act (ACA) are covered. For a list of ACA [preventative care services](#), visit <https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html>

**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 [plan](#) at 1.800.742.9944 or [www.imala.com](http://www.imala.com), the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Department of Health and Human Services and Center for Consumer Information and Insurance Oversight at 1.877.267.2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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: the [plan](#) at 1.800.742.9944 or [www.imala.com](http://www.imala.com), Louisiana Department of Insurance at 1.800.259.5300 or <https://www.lidi.la.gov/> or the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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? No

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](#).

-----*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](#) [coinsurance](#) Not covered
- [Hospital \(facility\)](#) [coinsurance](#) Not covered
- [Other](#) [coinsurance](#) Not covered

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,731</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                 |
|-----------------------------------|-----------------|
| Deductibles                       | \$0             |
| Copayments                        | \$0             |
| Coinsurance                       | \$0             |
| <i>What isn't covered</i>         |                 |
| Limits or exclusions              | \$12,528        |
| <b>The total Peg would pay is</b> | <b>\$12,528</b> |

### 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](#) [coinsurance](#) Not covered
- [Hospital \(facility\)](#) [coinsurance](#) Not covered
- [Other](#) [coinsurance](#) Not covered

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,389</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$0            |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$7,176        |
| <b>The total Joe would pay is</b> | <b>\$7,176</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [coinsurance](#) Not covered
- [Hospital \(facility\)](#) [coinsurance](#) Not covered
- [Other](#) [coinsurance](#) Not covered

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,925</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$0            |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$1,925        |
| <b>The total Mia would pay is</b> | <b>\$1,925</b> |

**The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.**

Only [preventative care services](#) required by the Affordable Care Act (ACA) are covered under this MEC [plan](#). For a list of ACA [preventative care services](#), visit <https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html>