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 employer. 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 https://www.healthcare.gov/sbc-glossary or call 866-805-2542 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In and Out-of-Network combined: Individual $1,000 / Family $3,000.	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. In-Network preventive care, services with a copay, and services covered at "No charge".	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?	Yes. $100 per individual for brand name prescription drugs. Not combined with Medical deductible.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In and Out-of-Network combined: Individual $3,000 / Family $9,000. Includes deductible	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?	Premiums, balance-billing charges, Pre-Certification penalties, 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.laferiaisd.net 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 can see the specialist you choose without a referral.

Benefits and cost sharing accumulate on a Calendar Year basis from 1/1 through 12/31 each year.

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies, unless otherwise stated.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	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 copay/visit, deductible does not apply	20% coinsurance	Includes Internist, General Practitioner, Family Practitioner, Pediatrician, Nurse Practitioner and OB/GYN.
	Specialist visit	$65 copay/visit, deductible does not apply	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Facility: 20% coinsurance after $250 copay/visit Physician: No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Facility: $300 copay/visit, deductible does not apply Physician: $50 copay/visit, deductible does not apply	20% coinsurance	None

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	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.maxor.com.	Generic drugs	Retail: $10 copay/prescription Mail Order: $20 copay/prescription	Not covered	Covers up to a 30 day supply (retail prescription), 90 day supply (mail order prescription). Includes contraceptive drugs and devices obtainable from a pharmacy, oral fertility drugs. No charge for formulary generic FDA approved women's contraceptives in-network. Drugs purchased in Mexico are covered at 50% after deductible.
	Preferred brand drugs	Retail: $100 prescription deductible then $35 or 50% copay up to $200 whichever is greater Mail Order: $100 prescription deductible then $70 or 50% copay up to $400 whichever is greater	Not covered	
	Non-preferred brand drugs	Retail: $100 prescription deductible then $35 or 50% copay up to $200 whichever is greater Mail Order: $100 prescription deductible then $70 or 50% copay up to $400 whichever is greater	Not covered	
	Specialty drugs	Generic: Retail: $10 copay/prescription; Mail Order: $20 copay/prescription Brand Name: $100 prescription deductible then $35 copay/ prescription or 50% copay up to $200 whichever is greater	Not covered	

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after $100 copay/visit, deductible does not apply	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	Facility: 20% coinsurance after $250 copay/visit, deductible does not apply Physician: 20% coinsurance, deductible does not apply	Facility: 20% coinsurance after $250 copay/visit, deductible does not apply Physician: 20% coinsurance, deductible does not apply	None
	Emergency medical transportation	20% coinsurance, deductible does not apply	20% coinsurance	None
	Urgent care	$50 copay/visit, deductible does not apply	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after $100 per day copay up to max $500 per confinement, deductible does not apply	20% coinsurance after $100 per day copay up to max $500 per confinement, deductible does not apply	50% penalty if Pre-Certification not obtained.
	Physician/surgeon fees	20% coinsurance, deductible does not apply	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient: 20% coinsurance, deductible does not apply Office: $35 copay/visit, deductible does not apply	20% coinsurance	None
	Inpatient services	20% coinsurance after $100 per day copay up to max $500 per confinement, deductible does not apply	20% coinsurance after $100 per day copay up to max $500 per confinement, deductible does not apply	50% penalty if Pre-Certification not obtained.
If you are pregnant	Office visits	$35 copay/visit, deductible does not apply	20% coinsurance	Maternity care is not covered for dependent Children.
	Childbirth/delivery professional services	20% coinsurance, deductible does not apply	20% coinsurance, deductible does not apply	Maternity care is not covered for dependent Children.

* For more information about limitations and exceptions, see the plan document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance after $100 per day copay up to max $500 per confinement, deductible does not apply	20% coinsurance after $100 per day copay up to max $500 per confinement, deductible does not apply	50% penalty if Post-Certification not obtained on admissions exceeding 48/96 hours. Maternity care is not covered for dependent Children.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	120 visits/calendar year
	Rehabilitation services	20% coinsurance	20% coinsurance	None
	Habilitation services	20% coinsurance	20% coinsurance	No coverage for learning disabilities
	Skilled nursing care	20% coinsurance after $500 copay/admission, deductible does not apply	20% coinsurance after $500 copay/admission, deductible does not apply	60 days/calendar year 50% penalty if Pre-Certification not obtained.
	Durable medical equipment	20% coinsurance, deductible does not apply	20% coinsurance	Charges for repair, adjustment or replacement of rented Durable Medical Equipment or components are not covered.
	Hospice services	$500 copay, deductible does not apply	$500 copay, deductible does not apply	50% penalty if Pre-Certification not obtained on inpatient admissions. $20,000 lifetime maximum
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

* For more information about limitations and exceptions, see the 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
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- 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.)

- Bariatric surgery ($5,000 Lifetime Maximum)
- Chiropractic care ($1,500 maximum per calendar year)

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 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 your employer or 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 a 866-805-2542.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866-805-2542.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 866-805-2542.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-805-2542.

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 document.

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 *[cost sharing]*	$65
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$130
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,490

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 *[cost sharing]*	$65
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,105
Coinsurance	$339
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,599

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

The plan's overall deductible	$1,000
Specialist *[cost sharing]*	$65
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$315
Coinsurance	$218
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$733

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