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 1-888-472-4352. 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.https://www.healthcare.gov/sbc-glossary.com or call 1-888-472-4352 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For PPO $750/individual, $1,500/family; Non-PPO Not covered	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, PPO preventive services, services paid with a copayment (except emergency room care), and services paid 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Medical coverage**: For PPO $4,000/individual, $8,000/family; Non-PPO Unlimited **Prescription drug coverage**: For PPO and Non-PPO pharmacies: $3,900/individual, $7,800/family.	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 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 (unless balance billing is prohibited), health care this plan doesn't cover, and Non-PPO expenses.	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.myGilsbar.com or call 1-888-472-4352 for a list of network providers.	This plan uses a provider network. Your charges will be covered if you use a provider in the plan's network. ***Your charges will not be covered*** if you use an out-of-network provider. 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
		PPO Provider	Non-PPO Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible does not apply; 20% coinsurance for other outpatient services.	Not covered	Copay is per provider and applies to office visit, injections (not including allergy testing or treatment), and minor office surgery.
	Specialist visit	$50 copay/visit, deductible does not apply; 20% coinsurance for other outpatient services.	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	Limited to annual routine physical exam, x-ray/lab, pap smear, colonoscopy (at any age if recommended by a Physician), prostatic/testicular exam, childhood hearing screening and vision exam. Mammograms are covered for participants age 35 and over. 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	Not covered	Precertification is required for Diagnostic tests over $1,000 or benefits could be reduced by 50%. Diagnostic tests in a standalone facility are paid at $50 copay/visit, deductible does not apply.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Precertification is required or benefits could be reduced by 50%.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider	Non-PPO Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myGilsbar.com	Generic drugs	Retail (up to 89-day supply): $10 copay/prescription Retail (90-day supply): $20 copay/prescription Mail order (90-day supply): $20 copay/prescription		Covers up to a 90-day supply through retail or mail order pharmacy. Preventive medication and contraceptives are covered at no charge as required by law. Insulin pumps are covered at no charge (limited to 1 every 5 years). Brand-name drug penalty: If your physician authorizes generic but you choose brand name, you pay the actual cost difference plus the brand name copayment. Purchases at a non-participating pharmacy require you to pay in full then submit a claim form for reimbursement.
	Preferred Brand Name drugs	Retail (30-day supply): $35 copay/prescription Retail (90-day supply): $70 copay/prescription Mail order (90-day supply): $70 copay/prescription		
	Non-preferred Brand Name drugs	Retail (30-day supply): $65 copay/prescription Retail (90-day supply): $130 copay/prescription Mail order (90-day supply): $130 copay/prescription		
	Specialty drugs	Retail (30-day supply): 20% of the cost of the drug up to a maximum of $300 copay/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Precertification is required for surgery over $1,000 or benefits could be reduced by 50%.
	Physician/surgeon fees	20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	$200 copay/visit, then 20% coinsurance	Emergency: $200 copay/visit, then 20% coinsurance Non-Emergency: Not covered	Copay waived if admitted to hospital from emergency room. No coverage for non-emergencies.
	Emergency medical transportation	20% coinsurance	Emergency: 20% coinsurance. Non-Emergency: Not covered	
	Urgent care	$55 copay/visit, deductible does not apply	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Precertification is required or benefits could be reduced by 50%. Room & Board is limited to the semiprivate room rate, or if the hospital has private rooms only, the private room rate billed.
	Physician/surgeon fees	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider	Non-PPO Provider	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not covered	Precertification is required for inpatient admissions or benefits could be reduced by 50%.
	Inpatient services	20% coinsurance	Not covered	
If you are pregnant	Office visits	20% coinsurance	Not covered	Precertification is required for an inpatient stay that is in excess of 48 hours (vaginal delivery) or 96 hours (caesarean delivery) or benefits could be reduced by 50%. Cost sharing does not apply for PPO preventive services.
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	60 visits/plan year
	Rehabilitation services	20% coinsurance	Not covered	Precertification is required for cardiac rehab & inpatient admissions or benefits could be reduced by 50%. Unless additional treatment is precertified, occupational, physical, & speech therapies are limited to the following combined maximums, per condition: 1) outpatient treatment: 3-month treatment plan and 2) inpatient admissions: 60 days. No coverage for vision therapy.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	Precertification is required or benefits could be reduced by 50%. 30 days/plan year.
	Durable medical equipment	20% coinsurance	Not covered	Precertification is required for DME & prosthetics over $500 or benefits could be reduced by 50%.
	Hospice services	20% coinsurance	Not covered	Limited to 90 days lifetime max. Bereavement counseling limited to 10 visits lifetime max and included in 90 days lifetime max for hospice care.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Covered under preventive services and a separate vision plan is available.
	Children's glasses	Not covered	Not covered	No coverage for children's glasses; however, a separate vision plan is available.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

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.)

- Cosmetic surgery
- Dental Care (Adult) / (Child)
- Emergency room care for non-emergency care
- Glasses
- Habilitation Services
- Hearing aid
- Infertility treatment (other than up to diagnosis)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) / (Child) except for childhood vision exam under preventive services
- Routine foot care
- Services from a Non-PPO provider
- Weight loss programs
- Vision Therapy

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

- Acupuncture (only if administered by a Medical Doctor or Doctor of Osteopathy)
- Bariatric Surgery (1 procedure lifetime max)
- Chiropractic Care (30 visits/plan year, further limited to $100 max/visit)
- Private-duty nursing (outpatient only)

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or 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 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: Claims Administrator: Gilsbar, Inc. | 1-888-472-4352 | www.myGilsbar.com or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 1-888-472-4352.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-472-4352.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-888-472-4352.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-472-4352.

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	$750
Specialist copayments	$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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$90
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,380**

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

The plan's overall deductible	$750
Specialist copayments	$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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$1,070
Coinsurance	$370
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,250**

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

The plan's overall deductible	$750
Specialist copayments	$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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$150
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,230**