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.allwaysmember.org or call Customer Services at 1-866-567-9175 (toll free) or 711 (TTY). 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.allwayshealthpartners.org or call 1-866-567-9175 (toll free) or 711 (TTY) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	See the Common Medical Events chart below for your costs for services this plan covers.
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?	**$4,500**/Individual, **$9,000**/Family per benefit period.	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 family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this **plan** doesn't cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. For a list of **in-network providers**, see www.allwayshealthpartners.org or call 1-866-567-9175.	If you use a network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. 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?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

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	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	None.
	Specialist visit	$30 copay/visit	Not covered	None.
	Preventive care/ screening/immunization	No charge	Not covered	Services for specific conditions during an annual exam may be subject to cost sharing.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None.
	Imaging (CT/PET scans, MRIs)	$50 copayment (maximum of one copayment per member per benefit period)	Not covered	May require prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.allwayshealthpartners.org.	Generic drugs	Retail: $10 copay Maintenance 90: $20 copay	Not covered	No charge for birth control and smoking cessation drugs.
	Preferred brand drugs	Retail: $30 copay Maintenance 90: $60 copay	Not covered	May require prior authorization.
	Non-preferred brand drugs	Retail: $55 copay Maintenance 90: $135 copay	Not covered	May require prior authorization.
	Specialty drugs	Generic: $10 Preferred brand drugs: $30 Non-preferred brand drugs: $55	Not covered	Copay based on tier of specialty drug. Prior authorization required for specialty drugs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider	Out-of-network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copayment (maximum of one copayment per member per benefit period)	Not covered	May require prior authorization.
	Physician/surgeon fees	No charge	Not covered	None.
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	Emergency room copay waived if admitted to hospital for inpatient care.
	Emergency medical transportation	No charge	No charge	None.
	Urgent care	$20 copay/visit	$20 copay/visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$50 copayment (maximum of one copayment per member per benefit period)	Not covered	May require prior authorization.
	Physician/surgeon fee	No charge	Not covered	None.
If you need mental health, behavioral health, or substance use services	Mental/behavioral health/substance use outpatient services	$20 copay/visit	Not covered	None.
	Mental/behavioral health/substance use inpatient services	No charge	Not covered	May require prior authorization.
If you are pregnant	Office visits for prenatal and postnatal care	No charge for routine prenatal and postnatal care	Not covered	None.
	Childbirth/delivery facility services	$50 copayment (maximum of one copayment per member per benefit period)	Not covered	May require prior authorization.
	Childbirth/delivery professional services	No charge	Not covered	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider	Out-of-network Provider	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	May require prior authorization.
	Rehabilitation services	Outpatient: $20 copay/visit Inpatient: $50 copayment (maximum of one copayment per member per benefit period)	Not covered	**Outpatient:** Covered up to 60 combined visits per benefit period for Physical Therapy/Occupational Therapy. Prior authorization required. **Inpatient:** Covered up to 60 days per benefit period. Prior authorization required.
	Habilitation services	Outpatient: $20 copay/visit Inpatient: $50 copayment (maximum of one copayment per member per benefit period)	Not covered	**Outpatient:** Covered up to 60 combined visits per benefit period for Physical Therapy/Occupational Therapy. Prior authorization required. **Inpatient:** Covered up to 60 days per benefit period. Prior authorization required. Cost and coverage limits are waived for early intervention services for eligible children.
	Skilled nursing care	$50 copayment (maximum of one copayment per member per benefit period)	Not covered	Covered up to 100 days per benefit period. May require prior authorization.
	Durable medical equipment	No charge	Not covered	May require prior authorization. No charge for electric breast pump (one every three years).
	Hospice service	No charge	Not covered	May require prior authorization.
If your child needs dental or eye care	Children's eye exam	$30 copay/visit	Not covered	One eye exam every 12 months per child covered under this plan.
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	No charge	Not covered	One dental check-up every 6 months per child under age 12 covered under this plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (adult age 12 and older)
- Extraction of infected or impacted wisdom teeth (except when in a hospital setting)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Hearing aids (age 21 and younger, covered up to $2000 per ear every 36 months)
- Infertility treatment
- Routine eye exam (adult)
- Routine foot care (covered for diabetes and some circulatory diseases)
- Weight loss program (coverage for six months of membership fees in a Jenny Craig or Weight Watchers program for either a covered Subscriber or one covered Dependent)

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 are: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services 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: Customer Service at **1-866-567-9175 (toll free) or 711 (TTY).**

Does this Coverage 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 Coverage Meet the Minimum Value Standard? 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: Para obtener asistencia en Español, llame al **1-866-567-9175.**

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

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 copayment	$30
Hospital (facility)	$0

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	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$160**

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 copayment	$30
Hospital (facility)	$0

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	$0
Copayments	$1,260
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,260**

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

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility)	$0

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	$0
Copayments	$270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$270**

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

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