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 855-697-2027. 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 or call 855-697-2027 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: **$1,000**/individual or **$2,000**/family Out-of-network provider: **$2,000**/individual or **$4,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. The deductible is **Embedded**. 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. **Deductible year runs 01/01 – 12/31**
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	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 care 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?	Network providers: **$2,500**/individual or **$5,000**/family Out-of-network providers: **$6,000**/individual or **$12,000**/family	The out-of-pocket limit is the most you could pay in a year for covered services. The out-of-pocket limit is **Embedded**. 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, 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.JHTNABenefits.com or call 855-697-2027 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).
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
		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	Ages 0-18: No charge Ages 19+: $30 copayment	30% coinsurance	Deductible does not apply to copayment.
	Specialist visit	Ages 0-18: No charge Ages 19+: $30 copayment	30% coinsurance	Deductible does not apply to copayment.
	Preventive care/screening/ immunization	No charge	30% coinsurance	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)	10% coinsurance	10% coinsurance	Labs in a clinic or independent lab setting are covered at no charge.
	Imaging (CT/PET scans, MRIs)	$100 copayment	30% coinsurance	May require preauthorization Deductible does not apply to copayment.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.JHTNABenefits.com	Generic drugs	30-day supply Retail: $10 copayment/Prescription 90-day supply Mail Order: $20 copayment/Prescription		Cost sharing does not apply for preventive Prescriptions. Deductible does not apply to copayment. Retail & Mail Order available up to a 90-day supply.
	Preferred brand drugs	30-day supply Retail: 25% coinsurance up to $50 90-day supply Mail Order: 25% coinsurance up to $100		
	Non-preferred brand drugs	30-day supply Retail: 50% coinsurance up to $80 90-day supply Mail Order: 50% coinsurance up to $160		
	Specialty drugs	30-day supply Retail & Mail Order: $100 copayment/Prescription		Retail & Mail Order available up to a 30-day supply. Deductible does not apply to copayment.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	May reqire preauthorization.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	

If you need immediate medical attention	Emergency room care	$200 copayment		Deductible does not apply to copayment.
	Emergency medical transportation	10% coinsurance		None.
	Urgent care	Ages 0-18: No charge Ages 19+: $30 copayment	$30 copayment	Deductible does not apply to copayment.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Ages 0-18: No charge Ages 19+: $30 copayment	30% coinsurance	Deductible does not apply to copayment.
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization required.
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Preauthorization required. 120 visits combined with home health care per year for in-network. 60 days per year maximum for out-of-network.
	Rehabilitation services	10% coinsurance	30% coinsurance	Occupational Therapy: No in-network limit. 20 visit limit for out-of-network Speech Therapy: No in-network limit. 20 visit limit for out-of-network Physical Therapy: No in-network limit. 20 visit limit for out-of-network. Deductible does not apply to copayment.
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Preauthorization required. 120 visits combined with home health care per year for in-network. 60 days per year maximum for out-of-network.
	Durable medical equipment	10% coinsurance	30% coinsurance	None.
	Hospice services	10% coinsurance	30% coinsurance	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	No Charge	30% coinsurance	Limit of 1 routine exam per year.
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	None.

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
- Weight loss programs
- Dental Care (Adult)
- Bariatric Surgery
- Acupuncture
- Long-term care
- Non-emergency care when traveling outside the U.S.

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

- Infertility Treatment (correction of physiological abnormalities)
- Routine Eye Care (one exam/year)
- Routine Foot Care
- Emergency care when traveling outside the U.S.
- Chiropractic Care
- Private Duty Nursing (inpatient 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 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: : 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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 855-697-2027
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-697-2027
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 855-697-2027
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-697-2027

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	$1,000
Specialist *Copayment*	$30
Hospital (facility) *Coinsurance*	10%
Other *Coinsurance*	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic test (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,270**

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 *Copayment*	$30
Hospital (facility) *Coinsurance*	10%
Other *Coinsurance*	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic test *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$400
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,520**

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

The plan's overall deductible	$1,000
Specialist *Copayment*	$30
Hospital (facility) *Coinsurance*	10%
Other *Coinsurance*	10%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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