



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 Customer Service at 1-800-649-9121. 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 (800) 649-9121 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 ?	Not applicable	Not applicable
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Network ("Panel") Providers: \$2,000 individual / \$4,000 family Out-of-Network ("Non-Panel") Providers: \$2,500 individual / unlimited family Prescription Drugs: \$2,000 individual / \$4,000 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 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, utilization management 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.pinnacletpa.com or call 1-800-649-9121 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 .



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	\$40 copay /visit	Not covered	None.
	Specialist visit	\$40 copay /visit	Not covered	None.
	Preventive care/screening/immunization	No charge	Not covered	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)	No charge	20% coinsurance	Out-of-network providers covered for emergency only.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medtrakrx.com .	Generic drugs (Tier 1)	\$10 copay /prescription	\$10 copay /prescription	Up to a 90-day supply. Preauthorization is required for certain medications. You may be balance billed for drugs obtained from an out-of-network pharmacy.
	Preferred brand drugs (Tier 2)	\$45 copay /prescription	\$45 copay /prescription	
	Non-preferred brand drugs (Tier 3)	\$60 copay /prescription	\$60 copay /prescription	
	Specialty drugs (Tier 4)	\$10/\$45/\$60 copay /prescription	Not covered	Up to a 30-day supply. Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Out-of-network providers covered for emergency only.
	Physician/surgeon fees	No charge	20% coinsurance	Out-of-network providers covered for emergency only.
If you need immediate medical attention	Emergency room care	\$250 copay	\$250 copay	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	None.
	Urgent care	\$25 copay	\$25 copay , then 20% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay /admission	\$500 copay /admission, then 20% coinsurance	Preauthorization is required, or benefits may be denied. Out-of-network providers covered for emergency only.
	Physician/surgeon fees	No charge	20% coinsurance	Out-of-network providers covered for emergency only.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay /visit No charge for other outpatient services.	Office visit not covered. 20% coinsurance for other outpatient services.	Out-of-network providers covered for emergency only.
	Inpatient services	\$500 copay /admission	\$500 copay /admission, then 20% coinsurance	Preauthorization required, or benefits may be denied. Out-of-network providers covered for emergency only.
If you are pregnant	Office visits	Prenatal: No charge Postnatal: \$40 copay /visit	Not covered	Cost sharing does not apply to preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Dependent daughters are not covered. Out-of-network providers covered for emergency only.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	\$500 copay /admission	\$500 copay , then 20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Preauthorization required, or benefits may be denied.
	Rehabilitation services	No charge	Not covered	None.
	Habilitation services	No charge	Not covered	None.
	Skilled nursing care	No charge	Not covered	Admission must be within 7 days of a 3-day hospital stay. Limit: 90 days per calendar year. Preauthorization is required, or benefits may be denied.
	Durable medical equipment	No charge	No coverage	None.
	Hospice services	No charge	Not covered	Preauthorization required, or benefits may be denied. Limit: 180 days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Must enroll in separate vision plan for benefits.
	Children's glasses	Not covered	Not covered	Must enroll in separate vision plan for benefits.
	Children's dental check-up	Not covered	Not covered	Must enroll in separate vision plan for benefits.

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 .)		
<ul style="list-style-type: none"> Cosmetic surgery Bariatric surgery Dental care Hearing aids 	<ul style="list-style-type: none"> Infertility treatment Long term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> 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.)

- Acupuncture
- Chiropractic care
- Private duty nursing

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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: Pinnacle Claims Management, Inc. at 1-800-649-9121.

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 1-800-649-9121.

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Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-649-9121.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-649-9121.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-649-9121.

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

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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 copay	\$40
■ Hospital (facility) copay	\$500

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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$560

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 copay	\$40
■ Hospital (facility) copay	\$500

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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copay	\$40
■ Hospital (facility) copay	\$500

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$700