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 HealthEZ at 1-844-839-6740. 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/pdf/sbcuniformglossary.pdf or call 1-844-839-6740 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: N/a Out-of-network services accumulate towards the in-network deductible.	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 to 12/31.**
Are there services covered before you meet your deductible?	Yes. Preventive care and primary 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 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?	Network providers: **$6,000**/individual or **$12,000**/family Out-of-network Provider: N/a Out-of-network services accumulate towards the in-network out-of-pocket.	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-billed charges, and health care this plan does not 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?	No.	
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/Visit		Deductible does not apply to copayment.
	Specialist visit	$60/Visit		Deductible does not apply to copayment.
	Preventive care/screening/ immunization	No Charge		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)	Office Visit: No Charge Outpatient: $250/Visit		Deductible does not apply to copayment.
	Imaging (CT/PET scans, MRIs)	$250/Visit		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.KennionPlansBenefits.com	Generic drugs	Retail: $15/Prescription Mail order: $37.50/Prescription		Retail and mail order available up to 90-day supply. Deductible does not apply to copayment.
	Preferred brand drugs	Retail: $50/Prescription Mail order: $125/Prescription		
	Non-preferred brand drugs	Retail: $100/Prescription Mail order: $250/Prescription		
	Specialty drugs	Retail & Mail Order: Not Covered		None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Facility: $250/Procedure Physician: No Charge		Preauthorization required for procedures performed outside of a physician's office. Deductible does not apply to copayment.
	Physician/Surgeon Fees	0% Coinsurance		
If you need immediate medical attention	Emergency room care	Facility: $250/Visit Physician: $60/Visit		Deductible does not apply to copayment.
	Emergency medical transportation	20% Coinsurance		None
	Urgent care	$60/Visit		Deductible does not apply to copayment.

If you have a hospital stay	Facility fee (e.g., hospital room)	Facility 1 – 5 Days: $250/Visit/Day Facility After 5 days: No Charge	Preauthorization required Deductible does not apply to copayment.
	Physician/surgeon fees	0% Coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60/Visit	Deductible does not apply to copayment.
	Inpatient services	Facility 1 – 5 Days: $250/Visit Facility After 5 Days: No Charge Physician: 0% Coinsurance	Preauthorization required Deductible does not apply to copayment.
If you are pregnant	Office visits	$60/Visit	Cost sharing does not apply to certain 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).
	Childbirth/delivery professional services	0% Coinsurance	
	Childbirth/delivery facility services	Facility 1 – 5 Days: $250/Visit/Day	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Preauthorization required
	Rehabilitation services	20% Coinsurance	30 visit limit per therapy per year. Chiropractic Services: 24 visit limit per year. Preauthorization required for occupational or speech therapy. Preauthorization required for physical therapy visits in excess of annual limit.
	Habilitation services	20% Coinsurance	
	Skilled nursing care	20% Coinsurance	Preauthorization required 60-day limit per year.
	Durable medical equipment	20% Coinsurance	None
	Hospice services	20% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not Covered	None
	Children's glasses	Not Covered	None
	Children's dental check-up	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
- Hearing Aids
- Bariatric Surgery
- 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 visit/yr covered at no cost for children under the age of 19)
- 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. For more information on your rights to continue coverage, contact the plan at 1-844-839-6740. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, your state insurance department, 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: HealthEZ at 1-844-839-6740 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 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 al 1-844-839-6740

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-839-6740

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-844-839-6740

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-839-6740

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 or policy document at www.KennionPlans.com

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	$60
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	$1,000
Copayments	$140
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,680**

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	$60
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	$1,000
Copayments	$1,430
Coinsurance	$370
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,860**

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

The plan's overall deductible	$1,000
Specialist copayment	$60
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	**$1,410**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$860
Copayments	$180
Coinsurance	$210
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**

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