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 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/healthreform or call 844-839-6740 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?	No.	You don't have to meet deductibles for specific services but see the chart starting on page 2 for other 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?	Not applicable	This plan does not have an out–of–pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable	This plan does not have an out–of–pocket limit on your expenses.
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	$25 copayment		Includes associated labs & x-rays.
	Specialist visit	$50 copayment		Chiropractic Services: 10 visit per year.
	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: Not Covered		Reference Based Pricing applies on Diagnostic tests in the hospital setting.
	Imaging (CT/PET scans, MRIs)	Stand Alone Facility: No charge Outpatient Hospital: $200 copayment		May require preauthorization. Reference Based Pricing applies on Imaging in the hospital setting.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at KennionPlans.com	Generic drugs	30-day supply Retail: $10/Prescription 90-day supply Mail Order: $20/Prescription		Cost sharing does not apply for preventive Prescriptions. Retail & Mail Order available up to a 90-day supply.
	Preferred brand drugs	30-day supply Retail: 100% copayment 90-day supply Mail Order: 100% copayment		
	Non-preferred brand drugs	30-day supply Retail: 100% copayment 90-day supply Mail Order: 100% copayment		
	Specialty drugs	Not Covered		None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered		None.
	Physician/surgeon fees	Not Covered		
If you need immediate medical attention	Emergency room care	$350 copayment		Reference Based Pricing applies.
	Emergency medical transportation	Not Covered		None.
	Urgent care	$75 copayment		None.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered		None.
	Physician/surgeon fees	Not Covered		None.

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	Not Covered		None.
	Inpatient services	Not Covered		None.
If you are pregnant	Office visits	$25 copayment		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	Not Covered		
	Childbirth/delivery facility services	Not Covered		
If you need help recovering or have other special health needs	Home health care	Not Covered		None.
	Rehabilitation services	Not Covered		None.
	Habilitation services	Not Covered		
	Skilled nursing care	Not Covered		None.
	Durable medical equipment	Not Covered		None.
	Hospice services	Not Covered		None.
If your child needs dental or eye care	Children's eye exam	No Charge		Limit of 1 routine exam per year.
	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
- Hearing Aids
- Long-term care
- Weight loss programs
- Bariatric Surgery
- 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. 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 844-839-6740
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-839-6740
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 844-839-6740
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-839-6740

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	$0
Specialist *Coinsurance*	$25
Hospital (facility) *Coinsurance*	100%
Other *Coinsurance*	100%

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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$12,840**

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 *Coinsurance*	$25
Hospital (facility) *Coinsurance*	100%
Other *Coinsurance*	100%

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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$7,460**

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

The plan's overall deductible	$0
Specialist *Coinsurance*	$25
Hospital (facility) *Coinsurance*	100%
Other *Coinsurance*	100%

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	**$1,368**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,410**

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