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 1-888-472-4352. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-888-472-4352 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	Network $3,500/self only $3,500/individual $7,000/family	Non-Network $10,500/individual $21,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Network: 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. Non-Network: If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
	Network and non-network deductibles are separate.		
Are there services covered before you meet your deductible?	Yes, network preventive services.		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 $6,000/self only $6,000/individual $12,000/family	Non-Network $18,000/individual $36,000/family	The out-of-pocket limit is the most you could pay in a year for covered services. Network: If you have other family members in this plan, they have to meet their out-of-pocket limits until the overall family out-of-pocket limit has been met. Non-Network: If you have other family members in this plan, the overall family out-of-pocket limit must be met.
	Network and non-network out-of-pocket limits are separate.		
What is not included in the out-of-pocket limit?	Premiums, balance billing charges (unless balance billing is prohibited), health care this plan doesn't cover, and penalties for failure to obtain pre-certification for services.		Even though you pay these expenses, they don't count toward the out-of-pocket limit.

* For more information about limitations and exceptions, see the plan or policy document at login.personifyhealth.com.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See login.personifyhealth.com or call 1-888-472-4352 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 a non-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 a non-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)	Non-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	20% coinsurance	50% coinsurance	Teladoc services are paid at 0% coinsurance. Visit www.teladoc.com or use the Teladoc App on your mobile device for more information.
	Specialist visit	20% coinsurance	50% coinsurance	
	Preventive care/screening/ immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Precertification is required or an Ineligible Expense Penalty of $750 may apply.

* For more information about limitations and exceptions, see the plan or policy document at login.personifyhealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at login.personifyhealth.com	Generic drugs	**Retail*** $5/prescription **Mail order** $15/prescription	$25/prescription	Covers up to a 90-day supply (network retail and mail order pharmacy). *90-day supply is covered at 3x copay. Purchases at a Non-Network pharmacy are limited to a 30-day supply. Brand-name drug penalty: If your physician authorizes generic but you choose brand name, you pay the actual cost difference plus the brand name copayment.
	Preferred brand drugs	**Retail*** $35/prescription **Mail order** $105/prescription	$55/prescription	
	Non-preferred brand drugs	**Retail*** $60/prescription **Mail order** $180/prescription	$80/prescription	
	Specialty drugs	Not covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance		None
	Emergency medical transportation	20% coinsurance		None
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Precertification is required or an Ineligible Expense Penalty of $750 may apply.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Teladoc services are paid at 0% coinsurance. Visit www.teladoc.com or use the Teladoc App on your mobile device for more information
	Inpatient services	20% coinsurance	50% coinsurance	Precertification is required or an Ineligible Expense Penalty of $750 may apply.

* For more information about limitations and exceptions, see the plan or policy document at login.personifyhealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply for network preventive care 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	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Precertification is required for an inpatient stay that is in excess of 48 hours (vaginal delivery) or 96 hours (caesarean delivery) or an Ineligible Expense Penalty of $750 may apply.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits/calendar year. Maximum does not apply to Dialysis services in the home setting. Precertification is required or an Ineligible Expense Penalty of $750 may apply.
	Rehabilitation services	20% coinsurance	50% coinsurance	Cardiac rehab, occupational and speech therapies limited to 40 visits/calendar year combined. Physical therapy limited to 20 visits/calendar year. Limits do not apply to Habilitation services for autism spectrum disorders.
	Habilitation services			
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days/calendar year. Precertification is required or an Ineligible Expense Penalty of $750 may apply.
	Durable medical equipment	20% coinsurance	50% coinsurance	None
	Hospice services	20% coinsurance	50% coinsurance	Limited to 60 visits/calendar year for outpatient services. Limit does not apply to Dialysis services in the home setting or mental health & substance use disorder conditions
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for children's eye exam.
	Children's glasses	Not covered	Not covered	No coverage for children's glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

* For more information about limitations and exceptions, see the plan or policy document at login.personifyhealth.com.

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental Care (Adult) / (Child)
- Hearing aid
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) / (Child)
- 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 (limited to 20 visits/calendar year)
- Chiropractic care (limited to 20 visits/calendar year)
- Habilitation services
- Private-duty nursing (outpatient only, 60 visits/calendar year in conjunction with Home Health Care)

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: Rocky Mountain Reserve 1-888-827-4479 or the 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 on how 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: Rocky Mountain Reserve 1-888-827-4479 or the 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 1-888-472-4352.

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** **$3,500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other (Tests) 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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,500
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,370**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$3,500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other (Brand drug) copayment** **$35**

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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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

- **The plan's overall deductible** **$3,500**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other (Physical Therapy) 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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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