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, visit us at www.ERSKelseyCare.com or call1-844-515-4877. 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 1-844-515-4877 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** individual/**$0** family	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 will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. **$50** for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. **$6,550** person / **$13,100** 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, the overall family out-of-pocket limit must be 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 http://www.ERSKelseyCare.com or call 1-844-515-4877 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	$15 copay/visit	Not covered	None
	Specialist visit	$25 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	Not covered	Physician office only. For diagnostic tests performed in a hospital, please refer to "If you have a hospital stay."
	Imaging (CT/PET scans, MRIs)	$150 copay per scan type per day	Not covered	Physician office only. For imaging performed in a hospital, please refer to "If you have a hospital stay." Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ERSKelseycare.com	Generic drugs	$10 copay (non-maintenance), $10 copay (maintenance); $30 copay (mail order or extended day supply)	Not covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Preferred brand drugs	$35 copay (non-maintenance); $45 copay (maintenance); $105 copay (mail order or extended day supply)	Not covered	Prior authorization may be required. Failure to obtain prior authorization may increase your costs. Note: If a generic drug is available and you choose to buy the preferred brand drug, you will pay the generic copay plus the cost difference between the preferred brand drug and the generic drug.
	Non-preferred brand drugs	$60 copay	Not covered	Prior authorization may be required.

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)	
		(non-maintenance); $75 copay (maintenance); $180 copay (mail order or extended day supply)		Failure to obtain prior authorization may increase your costs. Note: If a generic drug is available and you choose to buy the preferred brand drug, you will pay the generic copay plus the cost difference between the preferred brand drug and the generic drug.
	Specialty drugs	If purchased through the specialty mail-order pharmacy, specialty drugs are covered as preferred brand drugs or non-preferred brand drugs as listed above. Otherwise, covered as a medical benefit.	Not covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay	Not covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$150 copay plus 20% coinsurance	$150 copay plus 20% coinsurance	If admitted, copay is applied to inpatient hospital copay.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copay plus 20% coinsurance		None
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 per day copay per admission plus 20% coinsurance	Not covered	$750 copay max per admission. $2,250 copay max per plan year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fees	No charge	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	$25 copay	Not covered	None
	Inpatient services	$150/day copay per admission plus 20% coinsurance	Not covered	$750 copay max per admission. $2,250 copay max per plan year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you are pregnant	Office visits	No charge	Not covered	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	No charge	Not covered	None
	Childbirth/delivery facility services	$150/day copay per admission plus 20% coinsurance	Not covered	$750 copay max per admission. $2,250 copay max per plan year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Rehabilitation services	$25 copay/visit	Not covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Habilitation services	$25 copay/visit	Not covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Skilled nursing care	20% coinsurance	Not covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Durable medical equipment	20% coinsurance	Not covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Hospice services	20% coinsurance	Not covered	Prior authorization may be required.

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)	
				Failure to obtain prior authorization may increase your cost.
If your child needs dental or eye care	Children's eye exam	$25 copay/visit	Not covered	Limit of one routine exam per plan year per person.
	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.)

- Acupuncture
- Artificial insemination
- Bariatric surgery
- Cosmetic surgery
- Dental check-up
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal comfort items
- 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.)

- Chiropractic care
- Hearing aids
- Private duty nursing
- Routine eye exams

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**
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 1-844-515-4877.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-515-4877.
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-844-515-4877.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-515-4877.

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 copayment	$25
Hospital (facility) coinsurance	20%
Other copayment	$150

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 (Prescription)	$50
Copayments	$500
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,400**

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 copayment	$25
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles (Prescription)	$50
Copayments	$900
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,250**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	20%
Other copayment	$150

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles (Prescription)	$50
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$850**

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