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,(866) 363-2733. 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.ccio.cms.gov or call (866) 363-2733 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400/person**	Generally, you must pay all of the costs from providers up to the deductible amount before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and office visits 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.
Are there other deductibles for specific services?	**Yes, $400** per confinement if inpatient hospital stay is not pre-certified.	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?	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?	Yes, for professional services only. Please visit https://providerlookup.healthsmart.com/searchproviders.aspx and choose HealthSmart Physician/Ancillary Only, call (866) 363-2733, or download the HealthSmart app for a list of network providers. There is no network for institutional services (facilities).	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 a 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	$20/visit	60%	None
	Specialist visit	$20/visit	60%	Chiropractic services are limited to one (1) visit per week, twenty-six (26) visits per year.
	Preventive care/screening/ immunization	$20/visit	Not Covered	After $125, coinsurance applies
If you have a test	Diagnostic test (x-ray, blood work)	25%	60% when billed by a physician or independent lab / 25% when billed by a facility	Chiropractic x-rays payable at 50%. There is no network for facility claims.
	Imaging (CT/PET scans, MRIs)	25%	60% when billed by a physician or independent lab / 25% when billed by a facility	There is no network for facility claims.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	$15/prescription ($33.34/prescription for Mail Order)	100%	Opioid medication prescriptions may be subject to review and potential denial by a utilization management program if abuse is suspected. Please refer to the Summary Plan Description for additional information. Retail prescriptions must be filled at HAC owned pharmacies for coverage. Certain exceptions apply. Please see Section 4.07 of the SPD for more details.
	Preferred brand drugs	$33.34/prescription ($86.36/prescription for Mail Order)	100%	Opioid medication prescriptions may be subject to review and potential denial by a utilization management program if abuse is suspected. Please refer to the Summary Plan Description for additional information. Retail prescriptions must be filled at HAC owned pharmacies for coverage. Certain exceptions apply. Please see Section 4.07 of the SPD for more details.

[* For more information about limitations and exceptions, see the plan or policy document at https://v2.mybenefitplaninfo.com/NEBA]

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-preferred brand drugs	$46.68/prescription ($116.71/prescription for Mail Order)	100%	Opioid medication prescriptions may be subject to review and potential denial by a utilization management program if abuse is suspected. Please refer to the Summary Plan Description for additional information. Retail prescriptions must be filled at HAC owned pharmacies for coverage. Certain exceptions apply. Please see Section 4.07 of the SPD for more details.
	Specialty drugs	$33.34 for Preferred Brand; $46.68 for Non-Preferred Brand	100%	Prior Authorization is required for some Specialty and Compound drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25%	25%	There is no network for facility claims.
	Physician/surgeon fees	25%	60%	None
If you need immediate medical attention	Emergency room care	25%	25%	$66.69 Copayment for Sickness, $33.34 Copayment for Accident, waived if admitted to the same hospital within 48 hours. There is no network for facility claims.
	Emergency medical transportation	25%	60%	None
	Urgent care	$20/visit	60%	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25%	25%	Additional $400 Deductible applies for failure to pre-certify. There is no network for facility claims.
	Physician/surgeon fees	25%	60%	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25%	60% when billed by a physician or professional / 25% when billed by a facility	There is no network for facility claims.
	Inpatient services	25%	60% when billed by a physician or professional / 25% when billed by a	There is no network for facility claims.

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)	
			facility	
If you are pregnant	Office visits	$20/visit	60%	None
	Childbirth/delivery professional services	25%	60%	None
	Childbirth/delivery facility services	25%	25%	There is no network for facility claims.
If you need help recovering or have other special health needs	Home health care	25%	60%	30 days maximum per calendar year
	Rehabilitation services	25%	60% when billed by a physician or professional / 25% when billed by a facility	Additional $400 Deductible applies for failure to pre-certify. There is no network for facility claims.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	25%	60% when billed by a physician or professional / 25% when billed by a facility	There is no network for facility claims.
	Durable medical equipment	25%	60%	None
	Hospice services	25%	60%	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Exams covered once every 24 months
	Children's glasses	No Charge	Not Covered	Frames and Basic Lenses covered once every 24 months.
	Children's dental check-up	100%	100%	Two preventive visits per calendar year

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
- Bariatric Surgery
- Cosmetic Surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Routine eye care
- Dental care (adult)
- Private-duty Nursing

[* For more information about limitations and exceptions, see the plan or policy document at https://v2.mybenefitplaninfo.com/NEBA]

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: contact the plan at (866) 363-2733 or 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: the plan at (866) 363-2733 or 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 (866) 363-2733.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (866) 363-2733.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (866) 363-2733.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'(866) 363-2733.]

*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	**$400**
Specialist *copayment*	**$20**
Hospital (facility) *coinsurance*	**25%**
Other *coinsurance*	**25%**

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	$400
Copayments	$50
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,510**

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

The plan's overall deductible	**$400**
Specialist *[copayment]*	**$20**
Hospital (facility) *coinsurance*	**25%**
Other *coinsurance*	**25%**

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	$400
Copayments	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,500**

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

The plan's overall deductible	**$400**
Specialist *copayment*	**$20**
Hospital (facility) *coinsurance*	**25%**
Other *coinsurance*	**25%**

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	$400
Copayments	$100
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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