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. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.mycarehc.com/iag or call (800) 843-3831. 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 1-866-444-EBSA (3272) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Medical: $500** Individual per Coverage Year. **Rx:** N/A	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes, Preventive services, Primary care office visits, Specialist office visits, and Prescription drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. For example, this plan covers certain preventive services without cost sharing before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive -care-benefits/. 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket maximum for this plan?	**$5,000** Individual per Coverage Year	The out-of-pocket maximum is the most you could pay in a year for covered services.
What is not included in the out-of-pocket maximum?	Deductibles, copayments, prescription drug copayments, 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 maximum.
Will you pay less if you use a network provider?	No	This plan does not use a provider network. You can receive covered services from any provider.
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 FAIROS (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit, Deductible does not apply	**Fairos:** Includes hospitals, facilities and physicians. Determination for these providers will be made under the Plan's Claim Validation Program. Covered expenses will be considered under the Permitted Payment Levels, subject to the designated deductible, co-payments, co-insurance, maximums and limits. Provider copay is per day, per provider and applies to the office visit charge only.
	Specialist visit	$50 copay/visit, Deductible does not apply	
	Preventive care/screening/ immunization	No charge Deductible does not apply	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 (blood work)	Deductible then, 20% coinsurance	None
	Diagnostic test (x-ray)/ Imaging (CT/PET scans, MRIs)	Deductible then, 20% coinsurance	Precertification is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.fairosrx.com or by calling FairosRx at 833-464-9600.	Generic drugs	Retail: $15 copay/prescription Mail Order: $30 copay/prescription	Precertification, quantity limits, or step therapy may be required for some drugs. Copay applies to a 1-30-day supply (retail pharmacy), and a 31–90-day supply (mail order pharmacy). Specialty drugs are limited to a 30-day supply.
	Preferred brand drugs	Retail: $30 copay/prescription Mail Order: $60 copay/prescription	
	Non-preferred brand drugs	Retail: $45 copay/prescription Mail Order: $90 copay/prescription	
	Specialty drugs/Injections	Retail: $75 copay/prescription	

Common Medical Event	Services You May Need	What You Will Pay FAIROS (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then, $50 copay/visit; and 20% coinsurance	Precertification is required. **Fairos:** Includes hospitals, facilities and physicians. Determination for these providers will be made under the Plan's Claim Validation Program. Covered expenses will be considered under the Permitted Payment Levels, subject to the designated deductible, co-payments, co-insurance, maximums and limits.
	Physician/surgeon fees	Deductible then, 20% coinsurance	None
If you need immediate medical attention	Emergency room care	Deductible then, $250 copay/visit; and 20% coinsurance	The copay is waived if you are admitted to the hospital directly from the emergency room.
	Emergency medical transportation	Deductible then, 20% coinsurance	Air Ambulance is Not Covered
	Urgent care	Deductible then, $75 copay/visit; and 20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then, $50 copay/visit; and 20% coinsurance	Precertification is required. **Fairos:** Includes hospitals, facilities and physicians. Determination for these providers will be made under the Plan's Claim Validation Program. Covered expenses will be considered under the Permitted Payment Levels, subject to the Designated deductible, co-payments, co-insurance, maximums and limits.
	Physician/surgeon fees	Deductible then, 20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visit** $30 copay/visit, Deductible does not apply **Other Services** 20% coinsurance	Limited to 30 visits/$1,000 maximum per Plan Year.

Common Medical Event	Services You May Need	What You Will Pay FAIROS (You will pay the least)	Limitations, Exceptions, & Other Important Information
	Inpatient services	Deductible then, 20% coinsurance	Limited to 30 days/$10,000 maximum per Plan Year. Precertification is required.
If you are pregnant	Office visits	$30 copay/visit, Deductible does not apply	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance and deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Deductible then, 20% coinsurance	None
	Childbirth/delivery facility services	Deductible then, 20% coinsurance	Precertification is required for an inpatient stay that is in excess of 48 hours (vaginal delivery) or 96 hours (caesarean delivery).
If you need help recovering or have other special health needs	Home health care	Not Covered	None
	Rehabilitation services	Deductible then, 20% coinsurance	Limited to 20 visits per Plan Year. Precertification is required for Inpatient services.
	Habilitation services	Deductible then, 20% coinsurance	Limited to 20 visits per Plan Year Precertification is required for Inpatient services.
	Skilled nursing care	Not Covered	None
	Durable medical equipment	Deductible then, 20% coinsurance	Precertification is required.
	Hospice services	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.)

- Blood factors
- Cosmetic surgery
- Growth Hormones
- Hearing Aids
- Home Health services
- Hospice
- Infertility treatment
- Life-style Drugs
- Long-term care
- Private-duty nursing
- Routine foot care
- Skilled Nursing
- Weight Loss

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (20 visits per Plan Year)
- Chiropractic care (20 visits per Plan Year)

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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 HealthComp (800) 843-3831 or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov.

Does this plan provide Minimum Essential Coverage? **No**

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? **Not Applicable**

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 (800) 843-3831.

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** **$500**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$50**
- **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	$500
Copayments	$60
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,620**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$50**
- **Other (Brand drug) copayment** **$30**

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	$500
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$50**
- **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	$500
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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