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 1-844-380-4564. 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.webtpa.com or call 1-844-380-4564 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers $1,650/Employee or $3,300/Family; For out-of-network providers $3,300/Employee or $6,600/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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.
Are there services covered before you meet your deductible?	Yes. Preventive services 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. 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?	For in-network providers $5,000 Employee/ $13,000 Family; no more than $6,500 per person in a family. For out-of-network providers Employee/Family (unlimited)	The embedded 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the embedded out-of-pocket limit?	Premiums, balance-billing charges; bariatric surgery; non-precertification penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the embedded out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. **Call 1-844-380-4564** or visit www.mymohawkneighborhood.com for a list of in-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 in-network providers 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
		In-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	$35 copayment	50% coinsurance	_____none_____
	Specialist visit	$35 copayment	50% coinsurance	_____none_____
	Preventive care/screening/ immunization	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Preventive mammograms are limited to $225 max per occurrence. 3D mammograms are limited to $285 per occurrence. Maximum applies to technical component only; does not apply to professional services or related charges. Preventive colonoscopies are limited to $2,250 max per occurrence.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs, MRAs)	20% coinsurance	50% coinsurance	Precertification is required for PET, MRI's and MRA's, failure to pre-certify will result in a $500 penalty on facility charges only. MRI's and MRA's are limited to $2,300 per scan. CT and PET scans are limited to $2,000 per scan. Per scan maximum applies to physician's office, outpatient free standing imaging center and outpatient imaging department at a Hospital (non-ER location/non-urgent care). Does not apply to inpatient or emergency room. Precertification is not required for CT.

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-877-887-2879 or www.expressscripts.com	Generic drugs	20% coinsurance per prescription (retail) 20% coinsurance per prescription (mail order)	Not Covered	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (mail order). Coverage of maintenance medication is limited to 2 fills at retail, then mail order is required or a penalty will be assessed. Certain drugs are eligible for Walmart's $4 generic drug program for little or no out of pocket cost. Visit www.walmart.com and search "$4 drug list "
	Brand drugs	20% coinsurance per prescription (retail) 20% coinsurance per prescription (mail order)	Not Covered	Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (mail order). Coverage of maintenance medication is limited to 2 fills at retail, then mail order is required or 100% of the discounted cost will be assessed. Certain specialty drugs are excluded under the medical plan and must be obtained through the Express Scripts pharmacy; $100 per specialty prescription as defined by Express Scripts. $0.00 for qualified preventive medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Precertification is required, failure to pre-certify will result in a $500 penalty on facility charges only.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	_____none_____
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.
	Non-emergency care	20% coinsurance	50% coinsurance	
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-Emergent service is not covered.
	Urgent care	$25 copayment	20% coinsurance	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Precertification is required, failure to pre-certify will result in a $500 penalty on facility charges only.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	_____none_____

If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copayment	50% coinsurance	_____none_____
	Inpatient services	20% coinsurance	50% coinsurance	Precertification is required, failure to pre-certify will result in a $500 penalty on facility charges only.
If you are pregnant	Office visit to confirm pregnancy	$35 copayment	50% coinsurance	Dependent children covered for complications of pregnancy only
	Office visits in addition to Global Maternity Fee	$35 copayment	50% coinsurance	
	Global Maternity Fee (All subsequent prenatal visits, postnatal visits and physician's delivery charges).	20% coinsurance	50% coinsurance	_____none_____
	Delivery-Facility (Inpatient Hospital, Birthing Center)	20% coinsurance	50% coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Precertification is required, failure to pre-certify will result in a $500 penalty. 120 days (includes private duty nursing) per year, max 16 hours per day.
	Rehabilitation services	20% coinsurance	50% coinsurance	Precertification is required, failure to pre-certify will result in a $500 penalty. Speech, Occupational, Cardiac, Pulmonary and Cognitive therapies are all limited to 30 visits per therapy type per year. Physical therapy is limited to 60 visits per year maximum.
	Habilitation services	20% coinsurance	50% coinsurance	Precertification is required, failure to pre-certify will result in a $500 penalty. Speech, Occupational, Cardiac, Pulmonary and Cognitive therapies are all limited to 30 visits per therapy type per year. Physical therapy is limited to 60 visits per year maximum.
	Skilled nursing care	20% coinsurance	50% coinsurance	Precertification is required, failure to pre-certify will result in a $500 penalty.
	Durable medical equipment	20% coinsurance	50% coinsurance	Precertification is required over $1000. Failure to pre-certify will result in a $500 penalty.
	Hospice services	20% coinsurance	50% coinsurance	Precertification is required, failure to pre-certify will result in a $500 penalty. Must have a terminal illness with a life expectancy of 6 months or less as certified by the attending physician.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	_____none_____
	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
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Care (Children)
- Habilitation Services
- Hearing Aids
- Long-term care
- Non-Emergency Care when Traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Eye Care (Children)
- Weight Loss Programs

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

- Bariatric Surgery (In Network Surgeon only Lifetime Maximum $10,000)
- Routine Foot Care ($1,000 Maximum)
- Chiropractic Care (Maximum 12 Days)
- Private Duty Nursing
- Infertility Treatment

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/healthreformOther 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 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 1-844-380-4564
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-380-4564
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-844-380-4564
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-380-4564

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	$1650
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other 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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,650
Copayments	$70
Coinsurance	$2,487
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,267**
Total plan responsibility	**$8,464**

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

The plan's overall deductible	$1650
Specialist copayment	$35
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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,650
Copayments	$350
Coinsurance	$1,224
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,279**
Total plan responsibility	**$4,110**

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

The plan's overall deductible	$1650
Specialist copayment	$35
Hospital (facility) coinsurance	20%
Other 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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,306
Copayments	$105
Coinsurance	$326
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,737**
Total plan responsibility	**$188**

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