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 1-866-556-7655 or www.advantekbenefit.com. 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.cciio.cms.gov or call 1-866-556-7655 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$200** / person; 3 times individual / family Out-of-Network: **$200** / person; 3 times individual / 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. Does not apply to in-network services, ambulatory surgery centers, birthing centers, out-patient diagnostic testing, Hearing Screenings.	This plan covers items and services without meeting a deductible. But a copayment or coinsurance may apply. For example, this plan 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?	Medical Benefits: Network: **$4,350** / person; **$8,700** / family Out-of-Network: Unlimited Pharmacy Benefits: **$2,250** / person; **$4,500** / 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, 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 out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover. Rx copays, expenses in excess of non-Network UCR, non-Essential Health Benefits, and penalties for non-compliance with Utilization Management.	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 **www.netbyd.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 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 permission from this plan.

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
		Preferred 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	$25 copay / visit	50% coinsurance	Exam only
	Specialist visit	$25 copay / visit	50% coinsurance	Exam only
	Preventive care/screening/ immunization	No charge	50% coinsurance	Recommended frequency based on nationally required guidelines
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	Pre-authorization required for any single procedure exceeding $350 or benefits reduced by 50%.
	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance	Pre-authorization required or benefits reduced by 50%.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-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 www.caremark.com/wps/portal	Generic drugs	Retail: $7 copay / prescription. Mail Order: $14 copay / prescription.	Not covered	Retail: 34-day supply Mail order drugs are available in up to a 90-day supply with 1 Copay. The Plan requires that maintenance medications be obtained only through the Caremark mail order option or the Maintenance Choice Option at CVS Pharmacies after 2 fills at a retail pharmacy. If you are taking a brand-name drug, have not tried a generic form in the last 24 months and your doctor has not received prior approval for the brand-name drug, then your drug may not be covered by this Plan.
	Preferred brand drugs	Retail: $30 copay / prescription. Mail Order: $60 copay / prescription.	Not covered	
	Non-preferred brand drugs	Retail: $50 copay / prescription. Mail Order: $70 copay / prescription.	Not covered	
	Non-Formulary Drug	Retail: $50 copay / prescription. Mail Order: $100 copay / prescription.	Not covered	
	Specialty drugs	$100 copay / prescription (retail/mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	75% coinsurance	None
	Physician/surgeon fees	No charge	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay, then 15% coinsurance		Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	Hospital Based Facility: $100 copay, then 15% coinsurance Freestanding Clinic: $25 copay	Hospital Based Facility: $100 copay, then 50% coinsurance Freestanding Clinic: 50% coinsurance	Copay waived if admitted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	50% coinsurance	Pre-authorization required or additional $250 copay/admission
	Physician/surgeon fees	15% coinsurance	50% coinsurance	None
If you need mental health, substance abuse or behavioral health	Outpatient services	$25 copay / visit	50% coinsurance	Exam only
	Inpatient services	15% coinsurance	50% coinsurance	Pre-authorization required or additional $250 copay/admission
If you are pregnant	Office visits	$25 copay / visit	50% coinsurance	Cost sharing does not apply to certain preventive services. Exam visit.
	Childbirth/delivery professional services	15% coinsurance	50% coinsurance	No pre-authorization is required for 48 hours following a vaginal delivery and 96 hours following a cesarean delivery. If exceeds those hours, then pre-authorization required for mother and newborn or no benefits payable for noncompliance.
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	Limited to 100 visits calendar year. Visit equals 4 hours or less.
	Rehabilitation services	15% coinsurance	50% coinsurance	Proof of Medical Necessity required following 30 days of therapy without surgery and following 90 days of therapy with surgery
	Habilitation services	15% coinsurance	50% coinsurance	
	Skilled nursing care	First 30 days: 20% coinsurance. Next 30 days: 50% coinsurance.	First 30 days: 20% coinsurance. Next 30 days: 50% coinsurance.	Limited to 60 days / calendar year.
	Durable medical equipment	15% coinsurance	50% coinsurance	Requires pre-authorization for DME rentals and DME purchases over $500 or no additional benefit.
	Hospice services	20% coinsurance	20% coinsurance	Limted to $10,000 / lifetime
If your child needs dental or eye care	Children's eye exam	$15 copay / visit	Not covered	None
	Children's glasses	No cost for standard lenses w/ eye size < 61 mm	Not covered	Not covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	1st year: 30% coinsurance 2nd year: 20% coinsurance 3rd year: 10% coinsurance 4th year: No charge		Maximum $1,250 / 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.)

- Bariatric surgery
- Cosmetic surgery
- Glasses
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- 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 (pain management only)
- Chiropractic care
- Hearing aids ($1,000 in any 5-year period)
- Routine dental 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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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: Advantek Benefit Administrators, 1180 E. Shaw, Suite 225, Fresno, CA 93710, 1-866-566-7655 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 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 1-888-997-7717

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	$ 200
Specialist copayment	$25
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$80
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,040**

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

The plan's overall deductible	$ 200
Specialist copayment	$25
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$800
Coinsurance	$520
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,640**

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

The plan's overall deductible	$ 200
Specialist copayment	$25
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$80
Coinsurance	$280
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$660**

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