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, contact Prairie States Enterprises at 800-615-7020. 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 800-615-7020 for a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,500** Single / **$5,000** Family for network providers; **$5,000** Single / **$10,000** Family for out- of-network providers. Medical and pharmacy combined	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 policy, the overall family deductible (embedded) must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is not subject to 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 do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$5,000** Single / **$10,000** Family for network providers; **$8,000** Single / **$14,000** Family for out-of-network providers. Medical and pharmacy combined	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 limits (embedded) must be met before the plan begins to pay.
What is not included in the out-of-pocket limit?	DAW penalties (difference in cost between generic and brand prescriptions if generic alternative is available) manufacturer assistance programs for prescription drugs, premiums, balance-billing charges (unless balanced billing is prohibited), 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 www.prairieontheweb.com or call 800-615-7020 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	This plan allows you to see a specialist of your choice 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	$25 copayment/visit; deductible waived	50% coinsurance after deductible	
	Teladoc (Medical, Mental/Behavioral Health & Dermatology)	Deductible waived; covered 100% Medical Deductible waived; covered 100% Mental/Behavioral Health Deductible waived; covered 100% Dermatology	N/A	
	Chiropractic	10% coinsurance after deductible	50% after deductible	Chiropractic care limited to 24 treatments per plan year. Treatment includes all services provided during a calendar day including x-rays. Benefit limits are for services received from network and non-network providers.
	Specialist visit	$50 copayment/visit; deductible waived	50% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	10% coinsurance after deductible	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.
If you have a test	Diagnostic test (x-ray, blood work)	Included in office visit copayment if within 7 days of office visit; Others: x-ray and labs 10% coinsurance after deductible	50% coinsurance after deductible	None

* For more information about limitations and exceptions, see the plan or policy document by calling your Human Resources Dept or Prairie States.

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)	
	Imaging (CT/PET scans, MRIs)	High Value MRI: Covered 100%, deductible waived All others: 10% coinsurance after deductible	50% coinsurance after deductible	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from Navitus at http://www.navitus.com or by calling (855) 673-6504.	Generic drugs (Tier 1)	**Retail (30 days):** Covered 100%, deductible waived **Mail (90 days):** Covered 100%, deductible waived	Not Covered	Charges payable through the Plan's Pharmacy benefit Manager (PBM) program. If Physician does not prescribe "Dispense as Written" (DAW), and there is a generic alternative, and covered person chooses brand name instead, covered person must pay the difference in cost between generic and brand plus applicable brand copayment amount. Deductible and coinsurance may not apply to preventive care drugs as outlined in the Affordable Care Act (PPACA). Coverage is limited to 90-day supply for retail and mail order prescriptions. Certain prescriptions require prior authorization before the drug can be dispensed or before obtaining a second fill. Claims for non-participating pharmacies are not permitted. Additional coverage information can be found on your Navitus member materials.
	Preferred brand drugs (Tier 2)	**Retail (30 days):** $35 copayment; deductible waived **Mail (90 days):** $87.50 copayment; deductible waived	Not Covered	
	Non-preferred brand drugs (Tier 3)	**Retail (30 days):** $75 copayment after deductible **Mail (90 days)** $187.50 copayment after deductible	Not Covered	
	Specialty drugs (Tier 4)	20% coinsurance after Deductible; up to $437.50	Not Covered	Pre-certification is required

* For more information about limitations and exceptions, see the plan or policy document by calling your Human Resources Dept or Prairie States.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	ASC: Covered 100%; deductible waived Others:10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required
If you need immediate medical attention	Emergency room care	Facility: $350 copayment/visit; deductible waived	Facility: $350 copayment/visit; deductible waived	Copayment waived if admitted, and inpatient hospital benefits will apply.
	Emergency medical transportation	10% coinsurance after in-network deductible	10% coinsurance after in-network deductible	None
	Urgent care	$100 copayment/visit; deductible waived	50% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required for inpatient hospitalizations.
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Office visits	$25 copayment/visit; deductible waived	50% coinsurance after deductible	None
	Outpatient services	ASC: Covered 100%; deductible waived Others:10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required for inpatient hospitalizations
	Inpatient services	10% coinsurance after deductible	50% coinsurance after deductible	
If you are pregnant	Office visits	$25 copayment/visit PCP; deductible waived $50 copayment/visit SCP	50% coinsurance after deductible	Pre-certification is recommended for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. Maternity care may include

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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 billed per office visit; deductible waived		tests and services described elsewhere in the SBC (i.e. ultrasound) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
	Childbirth/delivery professional services	10% coinsurance after deductible if billed as a global fee	50% coinsurance after deductible	
	Childbirth/delivery facility services	10% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required
	Rehabilitation services	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification may be required for some therapy services.
	Habilitation services	10% coinsurance after deductible	50% coinsurance after deductible	None
	Skilled nursing care	10% coinsurance after deductible	50% coinsurance after deductible	Coverage limited to 120 days per Benefit Period; Limit applies for both Network and Non-Network Providers.
	Durable medical equipment	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required for all rentals, and any purchases over $500
	Hospice services	10% coinsurance after deductible	50% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	No charge deductible waived		Coverage limited to one exam, including refraction and retinal screening, per benefit period. This benefit can be waived, through waiver does not change the required contribution.
	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) • Long-Term 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.)		
• Bariatric Surgery • Chiropractic Care • Hearing Aids	• Infertility Treatment (medically necessary) • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult) • Private-Duty Nursing

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 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 al 1-800-615-7020.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-615-7020.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-615-7020.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-615-7020.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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** **$2,500**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$2,500
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$900
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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**

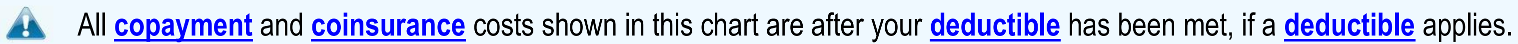
In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,600**

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

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, contact Prairie States Enterprises at 800-615-7020. 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 800-615-7020 for a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** Single / **$4,000** Family for network providers; **$6,000** Single / **$12,000** Family for out- of-network providers. Medical and pharmacy combined	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 policy, the overall family deductible (non-embedded) must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is not subject to 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 do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4,000** Single / **$8,000** Family for network providers; **$12,000** Single / **$24,000** Family for out- of-network providers. Medical and pharmacy combined	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 limits (non-embedded) must be met before the plan begins to pay.
What is not included in the out-of-pocket limit?	DAW penalties (difference in cost between generic and brand prescriptions if generic alternative is available) manufacturer assistance programs for prescription drugs, premiums, balance-billing charges (unless balanced billing is prohibited), 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 www.prairieontheweb.com or call 800-615-7020 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	This plan allows you to see a specialist of your choice 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 Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	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	Deductible applies then $25 copayment/visit	50% coinsurance after deductible	
	Teladoc (Medical, Mental/Behavioral Health & Dermatology)	Medical: Deductible applies then $55 consult fee Mental/Behavioral Health: Deductible applies then $220 / $100 / $90 Dermatology: Deductible applies then $85 consult fee	N/A	
	Chiropractic	10% coinsurance after deductible	50% coinsurance after deductible	Chiropractic care limited to 24 treatments per plan year. Treatment includes all services provided during a calendar day including x-rays. Benefit limits are for services received from network and non-network providers.
	Specialist visit	Deductible applies then $50 copayment/visit	50% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	50% coinsurance after deductible	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	50% coinsurance after deductible	None

* For more information about limitations and exceptions, see the plan or policy document by calling your Human Resources Dept or Prairie States.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available from Navitus at http://www.navitus.com or by calling (855) 673-6504.	Generic drugs (Tier 1)	20% coinsurance after deductible	Not Covered	Charges payable through the Plan's Pharmacy benefit Manager (PBM) program. If Physician does not prescribe "Dispense as Written" (DAW), and there is a generic alternative, and covered person chooses brand name instead, covered person must pay the difference in cost between generic and brand plus applicable brand copayment amount. Deductible and coinsurance may not apply to preventive care drugs as outlined in the Affordable Care Act (PPACA). Coverage is limited to 90-day supply for retail and mail order prescriptions. Certain prescriptions require prior authorization before the drug can be dispensed or before obtaining a second fill. Claims form non-participating pharmacies are not permitted. Additional coverage information can be found on your Navitus member materials.
	Preferred brand drugs (Tier 2)	20% coinsurance after deductible	Not Covered	
	Non-preferred brand drugs (Tier 3)	20% coinsurance after deductible	Not Covered	
	Specialty drugs (Tier 4)	20% coinsurance after deductible	Not Covered	Pre-certification is required
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required
If you need immediate medical attention	Emergency room care	Facility: Network deductible applies then $250 copayment/visit Provider: 10% coinsurance after deductible	Facility: Network deductible applies then $250 copayment/visit Provider: 10% coinsurance after deductible	Copayment waived if admitted, and inpatient hospital benefits will apply.

* For more information about limitations and exceptions, see the plan or policy document by calling your Human Resources Dept or Prairie States.

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)	
	Emergency medical transportation	10% coinsurance after network deductible	10% coinsurance after network deductible	None
	Urgent care	Deductible applies then $50 copayment/visit	50% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required for inpatient hospitalizations.
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Office visits	Deductible applies then $25 copayment/visit	50% coinsurance after deductible	None
	Outpatient services	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required for inpatient hospitalizations
	Inpatient services	10% coinsurance after deductible	50% coinsurance after deductible	
If you are pregnant	Office visits	Deductible applies then $25 copayment/visit PCP $50 copayment/visit SCP if billed per office visit	50% coinsurance after deductible	Pre-certification is recommended for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
	Childbirth/delivery professional services	10% coinsurance after deductible if billed as a global fee	50% coinsurance after deductible	
	Childbirth/delivery facility services	10% coinsurance after deductible	50% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required
	Rehabilitation services	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification may be required for some therapy services.
	Habilitation services	10% coinsurance after deductible	50% coinsurance after deductible	None
	Skilled nursing care	10% coinsurance after deductible	50% coinsurance after deductible	Coverage limited to 120 days per Benefit Period; Limit applies for both Network and Non-Network Providers.
	Durable medical equipment	10% coinsurance after deductible	50% coinsurance after deductible	Pre-certification is required for all rentals, and any purchases over $500
	Hospice services	10% coinsurance after deductible	50% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	No charge deductible waived		Coverage limited to one exam, including refraction and retinal screening, per benefit period. This benefit can be waived, through waiver does not change the required contribution.
	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)
- Long-Term 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.)

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment (medically necessary)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Private-Duty Nursing

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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: : the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 al 1-800-615-7020.

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Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-615-7020.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-615-7020.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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** **$2,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$2,000
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$2,000
Copayments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,720**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$2,000
Copayments	$400
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,410**

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