



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.houze.org/langdale or by calling 1-877-949-0940.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$800 person / \$2,000 family network providers \$2,500 person / No family non-network providers Doesn't apply to preventive care and prescription drugs	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	There are no other specific <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For network provider \$6,850 person/ \$13,700 family; For non-network providers <u>out-of-pocket limit</u> is unlimited	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, out-of-network coinsurance, balance-billed charges, additional deductible/penalties; and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of <u>network providers</u> , see www.tlcbenefitsolutions.net or call 1-877-949-0940.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist. To obtain network benefits, see Network Providers.	You can see the specialist you choose without permission from this plan.

Questions: Call 1-877-949-0940 or visit us at www.tlcbenefitsolutions.net.

If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-877-949-0940 to request a copy.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.
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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a SGPA Columbus Area Only Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	\$25 copay/visit	50% coinsurance	Coverage is limited to one (1) visit per day. Obstetrics and Gynecology is limited to two (2) primary care visits per year.
	Specialist visit	\$50 copay/visit	\$50 copay/visit	50% coinsurance	—none—
	Other practitioner office visit	\$50 copay/visit for chiropractor and acupuncture	\$50 copay/visit for chiropractor and acupuncture	50% coinsurance	Chiropractic services are limited to 20 visits per year. Acupuncture services are limited to 10 visits per year.
	Preventive care/screening/immunization	No charge	No charge	50% coinsurance	Coverage is limited to the Affordable Care Act requirements.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	10% coinsurance	50% coinsurance	Prior Authorization may be required
	Imaging (CT/PET scans, MRIs)	20% coinsurance	10% coinsurance	50% coinsurance	Prior Authorization may be required

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a SGPA Columbus Area Only Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at http://www.envisionrx.com/ and www.tlcbenefitsolutions.net.</p>	Generic drugs	\$15 copay/ prescription (retail order) \$45 copay/ prescription (mail order or retail 90 network)	\$15 copay/ prescription (retail order) \$45 copay/ prescription (mail order or retail 90 network)	Not Covered	Covers up to a 31-day supply or 90-day (retail prescription); 32-90 day supply (mail order prescription). Disease Management members pay \$10 and \$30, respectively. All members who adhere to their treatments will pay 2.5 times 31-day supply copay in retail 90 network, after initial fill.
	Preferred brand drugs	\$40 copay or 20% coinsurance (Greater Amount)/ prescription (retail order) \$120 copay or 20% coinsurance (Greater Amount)/ prescription (mail order or retail 90 network)	\$40 copay or 20% coinsurance (Greater Amount)/ prescription (retail order) \$120 copay or 20% coinsurance (Greater Amount)/ prescription (mail order or retail 90 network)	Not Covered	Covers up to a 31-day supply or 90-day (retail prescription); 32-90 day supply (mail order prescription) Therapy Class Restrictions Apply. Disease Management members pay \$30 (or 20%) and \$90 (or 20%), respectively.
	Non-preferred brand drugs	\$75 copay or 30% coinsurance (Greater Amount)/ prescription (retail order) \$225 copay or 30% coinsurance (Greater Amount)/ prescription (mail order or retail 90 network)	\$75 copay or 30% coinsurance (Greater Amount)/ prescription (retail order) \$225 copay or 30% coinsurance (Greater Amount)/ prescription (mail order or retail 90 network)	Not Covered	Covers up to a 31-day supply or 90-day (retail prescription); 32-90 day supply (mail order prescription) Therapy Class Restrictions Apply.
	Specialty drugs	\$250 copay/ prescription (mail order)	\$250 copay/prescription (mail order)	Not Covered	Covers up to a 31-day supply (mail order and retail specialty prescription) Prior Authorization may be required. Drug specific copayments may apply.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a SGPA Columbus Area Only Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	10% coinsurance	50% coinsurance	Prior Authorization is required
	Physician/surgeon fees	20% coinsurance	10% coinsurance	50% coinsurance	Prior Authorization is required
If you need immediate medical attention	Emergency room services	20% coinsurance	10% coinsurance	20% coinsurance	\$1,000 Penalty and 50% coinsurance for routine care in ER.
	Emergency medical transportation	20% coinsurance	10% coinsurance	20% coinsurance	Coverage limited to Medical Necessity.
	Urgent care	\$50 copay/visit	\$50 copay/visit	50% coinsurance	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	10% coinsurance	50% coinsurance	Prior Authorization is required
	Physician/surgeon fee	20% coinsurance	10% coinsurance	50% coinsurance	Prior Authorization is required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$25 copay/office visit and 20% coinsurance other outpatient services	\$25 copay/office visit and 20% coinsurance other outpatient services	50% coinsurance	Prior Authorization may be required
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	50% coinsurance	Prior Authorization is required
	Substance use disorder outpatient services	\$25 copay/office visit and 20% coinsurance other outpatient services	\$25 copay/office visit and 20% coinsurance other outpatient services	50% coinsurance	Prior Authorization may be required
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	50% coinsurance	Prior Authorization is required
If you are pregnant	Prenatal and postnatal care	20% coinsurance	10% coinsurance	50% coinsurance	Preventive services under the Affordable Care Act are covered at No Charge.
	Delivery and all inpatient services	20% coinsurance	10% coinsurance	50% coinsurance	Prior Authorization may be required

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a SGPA Columbus Area Only Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	10% coinsurance	50% coinsurance	Coverage is limited to one (1) visit per day and 120 days per year. Prior Authorization is required
	Rehabilitation services	20% coinsurance	10% coinsurance	50% coinsurance	Prior Authorization is required
	Habilitation services	20% coinsurance	10% coinsurance	50% coinsurance	Prior Authorization is required
	Skilled nursing care	20% coinsurance	10% coinsurance	50% coinsurance	Coverage is limited to 120 days per year. Prior Authorization is required
	Durable medical equipment	20% coinsurance	10% coinsurance	50% coinsurance	Prior Authorization may be required
	Hospice service	20% coinsurance	10% coinsurance	50% coinsurance	Coverage is limited to 30 days per benefit period. Prior Authorization is required
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered	—————none—————
	Glasses	Not Covered	Not Covered	Not Covered	—————none—————
	Dental check-up	Not Covered	Not Covered	Not Covered	—————none—————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
• Bariatric surgery	• Hearing aids	• Private-duty nursing
• Care when traveling outside the U.S.	• Home Health Aide	• Routine eye care
• Cosmetic surgery	• Infertility treatment	• Routine foot care
• Dental care	• Long-term care	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-949-0940. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1-877-949-0940. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Para obtener asistencia en Español, llame al 1-877-949-0940.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,280
- Patient pays \$2,260

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$800
Copays	\$20
Coinsurance	\$1,290
Limits or exclusions	\$150
Total	\$2,260

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,600
- Patient pays \$1,800

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$800
Copays	\$600
Coinsurance	\$320
Limits or exclusions	\$80
Total	\$1,800

Note: These numbers assume the patient is participating in our disease management program. If you have diabetes and do not participate in the disease management program, your costs may be higher. For more information about the disease management program, please contact: TLC Benefit Solutions, Inc. at 1-877-949-0940.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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