

 **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 TLC Benefit Solutions, Inc. at 877-949-0940. 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.tlcbenefitsolutions.com](http://www.tlcbenefitsolutions.com) or call 877-949-0940 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$800/Individual or \$2,000/family</b> in-network providers <b>\$2,500/Individual or unlimited/</b> family out-of-network providers	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">network providers</a> <b>\$7,100</b> individual / <b>\$14,200</b> family; for <a href="#">out-of-network providers</a> unlimited	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.tlcbenefitsolutions.com">www.tlcbenefitsolutions.com</a> or call 877-949-0940 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /office visit and <a href="#">deductible</a> and 20% <a href="#">coinsurance</a> for other outpatient services	50% <a href="#">coinsurance</a>	Coverage is limited to one (1) visit per day.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	Chiropractic services are limited to 20 visits per year. Acupuncture services are limited to 10 visits per year.
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.tlcbenefitsolutions.com">www.tlcbenefitsolutions.com</a>	Generic drugs	\$15 <a href="#">copay</a> / prescription (retail order) \$45 <a href="#">copay</a> / prescription (retail 90 network)	Non-Preferred Provider: \$25 <a href="#">copay</a> / 31-day supply	Covers up to a 34-day supply or 90-day (retail prescription); <b>Disease Management</b> members pay \$10 and \$30, respectively (Network Provider). <b>Diabetes Management</b> members pay \$0 through the FiveStar Telehealth Clinic.
	Preferred brand drugs	\$40 <a href="#">copay</a> or 20% <a href="#">coinsurance</a> (Greater Amount)/ prescription (retail order) \$120 <a href="#">copay</a> or 20% <a href="#">coinsurance</a> (Greater Amount)/ prescription (retail 90 network)	Non-Preferred Provider: \$50 <a href="#">copay</a> or 20% /31-day supply	Covers up to a 34-day supply or 90-day (retail prescription); Therapy Class Restrictions Apply. <b>Disease Management</b> members pay \$30 (or 20%) and \$90 (or 20%), respectively (Network Provider). <b>Diabetes Management</b> members pay \$0 through the FiveStar Telehealth Clinic.
	Non-preferred brand drugs	\$75 <a href="#">copay</a> or 30% <a href="#">coinsurance</a> (Greater Amount)/ prescription (retail order)	Non-Preferred Provider: \$90 <a href="#">copay</a> or 30% /31-day supply	Covers up to a 34-day supply or 90-day (retail prescription). Therapy Class Restrictions Apply. <b>Disease Management</b> members pay the

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)	
		\$225 <a href="#">copay</a> or 30% <a href="#">coinsurance</a> (Greater Amount)/ prescription (retail 90 network)		same amount. <b>Diabetes Management</b> members pay \$0 through the FiveStar Telehealth Clinic.
	<a href="#">Specialty drugs</a>	Not Covered	Not Covered	Specialty Concierge services available
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200/day <a href="#">copay</a>	\$200/day <a href="#">copay</a>	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay</a> /office visit and 20% <a href="#">coinsurance</a> for other outpatient services	50% <a href="#">coinsurance</a> 20% <a href="#">coinsurance</a> for Facility fee	None
	Inpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required
If you are pregnant	Office visits	\$50 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> .
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for longer than expected stays
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	1 visit/day and 120 days/year. Prior Authorization is required
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	120 days/year. <a href="#">Preauthorization</a> is required
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required
	<a href="#">Hospice services</a>	No Charge (Includes Home Health by Hospice)	20% <a href="#">coinsurance</a>	30 day/benefit period. <a href="#">Preauthorization</a> is required

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 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](#).)

- Bariatric Surgery (with the exception of approved Gastric Sleeve procedures)
- Cosmetic Surgery
- Dental Care
- Hearing Aids (with the exception of hearing aids for children age 18 and under)
- Home Health Aide, when not provided by Hospice
- Infertility Treatment
- Long-term Care
- Non-emergency Care when traveling outside the U.S.
- Private-duty Nursing
- Routine Eye Care
- Routine Foot Care

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

- Acupuncture
- Chiropractic Care
- Orthospinology

**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](http://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](http://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 TLC Benefit Solutions, Inc. 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](http://www.dol.gov/ebsa/healthreform).

**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:

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 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$800
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$70
Coinsurance	\$2400
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,270</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$800
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$500
Coinsurance	\$1000
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2300</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$800
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$400
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1300</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: TLC Benefit Solutions, Inc. at 1-877-949-0940.