

Subject to plan allowable **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 1-888-405-5157. 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.dol.gov/ebsa/healthreform.com](http://www.dol.gov/ebsa/healthreform.com) or [www.cciio.cms.gov](http://www.cciio.cms.gov)

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| What is the overall <a href="#">deductible</a> ?                                | Individual \$250 / Family Unit \$500                 | You will have to cover the first \$250 / \$500 for all services.                         |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | No   | No benefits before deductible is met.  |
| Are there other <a href="#">deductibles</a> for specific services?              | None   | No other deductibles for specific services   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | None   | There is no out-of-pocket limit for this plan.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Not applicable                                       | There is no out-of-pocket limit for this plan.   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes, you will pay less if you use network providers. | There are no network restrictions for this plan.   |
| What is the yearly benefit maximum?   | \$1,000,000  | There is a \$1,000,000 per member, per Plan year maximum.                                |
| What is the lifetime benefit maximum?   | \$5,000,000  | There is a \$5,000,000 per member, per lifetime maximum.                                 |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No. You don't need a referral to see a specialist.   | You can see the <a href="#">specialist</a> you choose without permission from this plan. |

| Common Medical Event  | Services You May Need  | Member out of pocket  | Limitations, Exceptions, & Other Important Information   |
|---|--|---|--|
| <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 (10 per benefit period)   | \$50 <a href="#">copay</a> /visit (after deductible)                | 10 visit per benefit period maximum is combined for PCP office visits, Specialist office visits, and Urgent Care visits.   |
|   | <a href="#">Specialist</a> visit   | \$50 <a href="#">copay</a> /visit (after deductible)                | 10 visit per benefit period maximum is combined for PCP office visits, Specialist office visits, and Urgent Care visits.   |
|   | <a href="#">Preventive care/screening/</a> Immunization.   | No charge   | 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 <a href="#">preventive</a> . Services are limited to those covered by the Affordable Care Act. All services must be conducted in office, hospital services are not covered. |
|   | Tele-Medicine – General Medicine<br>Tele-Medicine – Mental Health<br>Tele-Medicine – Urgent Care                                       | No charge on all Tele-Medicine when you use the MyLiveDoc Platform. | 12 visits limit per benefit year. Includes Dermatology.<br>4 visits limit per benefit year.<br>Unlimited through Tele-Medicine Platform.   |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (X-Ray, Lab, EKGs, ECGs, All other diagnostic services not included in Imaging) (3 per benefit period) | \$50 <a href="#">copay</a> per visit (after deductible)             | 3 per benefit period maximum.  |
|   | Imaging (CT/PET scans, MRIs, MRAs) (3 per benefit period)  | \$250 <a href="#">copay</a> per visit (after deductible)            | 3 per benefit period maximum.  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mylivepharmacy.com">www.mylivepharmacy.com</a> | Generic drugs  | Limited   | Please see your Tele-Medicine Formulary  |
|   | Preferred brand drugs  | Limited   | Please see your Tele-Medicine Formulary  |
|   | Non-preferred brand drugs  | Not covered   | None   |

[\* For more information about limitations and exceptions, see the plan or policy document at [www.detegohealth.com](http://www.detegohealth.com)

| Common Medical Event   | Services You May Need  | Member out of pocket   | Limitations, Exceptions, & Other Important Information  |
|--|--|--|---|
|  | <u>Specialty drugs</u>   | Not covered  | None  |
| <b>If you have outpatient surgery</b>  | Outpatient Hospital/Ambulatory Surgical Center, All fees                   | \$250 copay/surgery (after deductible)   | 3 Surgeries Per Plan Year limit.  |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>   | \$250 copay/visit (after deductible)   | 2 visit limit per benefit period for Accident related visits. 2 visit limit per benefit period for Sickness related visits.   |
|  | <u>Emergency medical transportation</u>                                    | No charge  | 2 visit per benefit period maximum. Combined for Ground and Air ambulance services.   |
|  | <u>Urgent care</u><br>-  | \$50 <u>copay</u> /visit (after deductible)  | 10 visit per benefit period maximum is combined for PCP office visits, Specialist office visits, and Urgent Care visits.  |
| <b>If you have a hospital stay</b>   | Inpatient Hospital Services, Facility/Physician fees                       | \$1,000 copay/admission (after deductible)   | Paid at facility's semi-private room rate. Non-ICU stays limited to 2 hospitalizations per benefit period. ICU stays limited to 3 hospitalizations per benefit period. 10 day limit per hospitalization.              |
|  | Inpatient Hospital Surgical Services, All fees                             | \$1,000 copay/surgery (after deductible)   | 2 surgeries per Plan year.  |
| <b>If you need mental health, behavioral health and substance abuse services</b> | Outpatient services  | No Coverage  | None  |
|  | Inpatient services   | \$250 copay/admission (after deductible)   | Includes Facility and Professional Fees Included in the inpatient hospitalization limit.  |
| <b>If you are pregnant</b>   | Global Maternity Services, All Fees  | \$250 copay per admission, Vaginal delivery<br>\$500 copay per admission, C-Section delivery<br>100% coverage for other maternity services | Other maternity services include office visits, lab work, radiology, prenatal/postnatal care, etc. Capped at \$15,000 Per Plan Year. Excludes Genetic testing unless medically necessary.                             |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>  | \$50 copay/visit (after deductible)  | \$500 maximum per benefit period.   |
|  | Therapies (Chiropractic, PT/OT/ST, Cardiac)<br>(Precertification Required) | \$50 copay/visit (after deductible)  | 10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits, Therapies (Chiropractic, PT/OT/ST, Cardiac), Mental Health/Behavioral Health/Autism/Substance Abuse office visits. |
|  | <u>Skilled nursing care</u>  | \$50 copay/day (after deductible)  | \$5,000 maximum per benefit period.   |

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| Common Medical Event                          | Services You May Need            | Member out of pocket  | Limitations, Exceptions, & Other Important Information   |
|---|----------------------------------|---|--|
|   | <u>Durable medical equipment</u> | \$50 copay/item (after deductible)                            | \$500 maximum per benefit period. Copayment is applied per item received.                        |
|   | Infusion/Injection drugs         | \$100 copay/visit (after deductible)                          | \$50,000 Benefit Max Per Plan Year. Maximum combined with chemotherapy/radiation benefit.        |
|   | Diabetic Nutritional Counseling  | No charge (after deductible)                                  | 1 visit per plan year  |
|   | Allergy visits/testing           | \$100 copay/visit (after deductible)                          | 4 visit per plan year  |
|   | Allergy shots                    | \$25 copay/visit (after deductible)                           | 25 visit per plan year   |
|   | Prosthetics                      | \$50 copay/item (after deductible)                            | \$2,500 maximum per benefit period. Copayment is applied per item received.                      |
|   | Diabetic supplies/equipment      | DiaThrive: No Cost to Member<br>Non-DiaThrive: Plan Allowable | See DiaThrive information for more details.<br>\$250 Max Per Plan Year (after deductible)        |
|   | Chemotherapy/Radiation           | \$100 copay/visit (after deductible)                          | \$50,000 Benefit Max Per Plan Year. Maximum combined with infusion and injections drugs benefit. |
|   | Hospice services                 | No charge (after deductible)                                  | \$5,000 maximum per benefit period.  |
|   | Dialysis                         | Not covered   |  |
|   | Organ Transplant Services        | Not covered   |  |
| <b>If your child needs dental or eye care</b> | Child Eye exam                   | Not covered   |  |
|   | Child Glasses/Contacts           | Not covered   |  |
|   | Child Dental check-up            | Not covered   |  |

### Excluded Services & Other Covered Services:

| <b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u>.)</b> |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Children's Dental Check-up</li> <li>Children's Glasses/Contacts</li> </ul>                                | <ul style="list-style-type: none"> <li>Children's Eye Exam</li> <li>Dialysis</li> <li>Biofeedback</li> </ul> | <ul style="list-style-type: none"> <li>Mental Health Services (except for Telemedicine)</li> <li>Substance Abuse Services</li> <li>Organ Transplant Services</li> </ul> |

| <b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>                         |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>Annual Lab / X-Ray Tests</li> <li>Annual Pap Smear / Mammogram</li> <li>Cancer Screenings</li> <li>Colonoscopies</li> </ul> | <ul style="list-style-type: none"> <li>Diabetic Supply</li> <li>Immunizations</li> <li>Other Preventative Screenings</li> <li>MyLiveDoc</li> </ul> | <ul style="list-style-type: none"> <li>Tele-Medicine (Including Mental Health)</li> <li>Urgent care and office visits</li> <li>Well Baby Care</li> <li>Wellness Visits</li> </ul> |

**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/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage

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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: Performance Health at 866-815-6001 or 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)

**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 [866-815-6001]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [866-815-6001]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[866-815-6001]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [866-815-6001]

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*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 pre-natal care and a hospital delivery)

|   |             |
|---|-------------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$250       |
| ■ <a href="#">Specialist</a>                                    | No charge   |
| ■ Hospital (facility, c-section)                                | \$1,000     |
| ■ Other   | No Coverage |

#### 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>\$7,540</b> |
|---------------------------|----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$250          |
| Copayments                        | \$1,000        |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$1,250</b> |

### Managing Joe's type 2 Diabetes

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

|                              |      |
|------------------------------|------|
| ■ <a href="#">Specialist</a> | \$50 |
| ■ Diagnostic testing         | \$50 |
| ■ Other                      | \$50 |

#### 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>\$5,400</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$250        |
| Copayments                        | \$150        |
| Coinsurance                       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Joe would pay is</b> | <b>\$400</b> |

### Mia's Simple Fracture

(emergency room visit and follow up care)

|   |       |
|---|-------|
| The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$250 |
| ■ <a href="#">Specialist</a>                                  | \$250 |
| ■ Hospital (facility)   | \$50  |
| ■ Other   | \$50  |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic tests (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,500</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| Deductibles                       | \$250        |
| Copayments                        | \$350        |
| Coinsurance                       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$600</b> |