
 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 or www.cciio.cms.gov

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0 There is no deductible .	Generally, you must pay all 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 other deductibles for specific services?	No. Preventive care services are covered before any out-of-pocket costs.	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 .
What is the out-of-pocket limit for this plan ?	The Plan is a Minimum Essential Coverage (MEC) Plan and has no out-of-pocket limit for covered services.	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 must 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 ?	This Plan does not have an out-of-Pocket limit .	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	Using network Providers for covered services can protect against balance billing. This plan offers First Health for covered services. Look up at docfind.health
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	See Plan Document for details

 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 Per Visit		4 Visits Per Year for Single and 8 for Other (Maximum \$150 Subject to Plan Allowable)
	Specialist visit	\$50 Per Visit		1 Visits Per Year (Maximum \$300 Per Visit) Subject to Plan Allowable
	Preventive care/screening/immunization	\$0 Per Visit		1 Visit Per Year (Maximum \$150 Per Visit) Subject to Plan Allowable
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered		Discount Lab Services Available through Quest Direct Labs Program
	Imaging (CT/PET scans, MRIs)	Not Covered		Discounts available through Green Imaging
If you need drugs to treat your illness or condition	Generic Drugs	Available through Scriptco https://scriptco.com/my-account/rewards/		Formulary Only https://scriptco.com/my-account/rewards/
	Preferred brand drugs & Specialty	Not Covered		Specialty & High-Cost Meds are available through PAP only. Note, PAP requires members to meet certain financial criteria
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) & Physician Surgery Fees	Not Covered		
If you need immediate medical attention	Emergency room care	Not Covered		
	Emergency medical transportation	Not Covered		
	Urgent care	\$0 Per visit		3 Visits Per Year - Covered by CGA Urgent Care Subject to Plan Allowable

[* For more information about limitations and exceptions, see the plan or policy document at www.detegohealth.com]

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000/Per Event	\$3,000/ Year Maximum Subject to Plan Allowable
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Available through Clever Health https://www.cleverhealth.ai/ only	Subject to Plan Allowable
	Inpatient services	Not Covered	

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 .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Infertility treatments • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult) • 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.)

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. 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: M2 Benefits at 888-405-5157 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes

[* For more information about limitations and exceptions, see the plan or policy document at www.detegohealth.com]

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 [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]

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](#) \$0
- [Specialist \[cost sharing\]](#) \$0
- [Hospital \(facility\) \[cost sharing\]](#) 100%
- [Other \[cost sharing\]](#) 100%

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	\$8,000
---------------------------	----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$8,000
The total Peg would pay is	\$8,000

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$0
- [Hospital \(facility\) \[cost sharing\]](#) 100%
- [Other \[cost sharing\]](#) 100%

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	\$500
---------------------------	--------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$50
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$300
The total Joe would pay is	\$350

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) \$0
- [Hospital \(facility\) \[cost sharing\]](#) 100%
- [Other \[cost sharing\]](#) 100%

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	\$1,500
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1500
The total Mia would pay is	\$1500