|  |  |
| --- | --- |
| **Description: Exclamation** | **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, visit [www.mygilsbar.com](http://www.mygilsbar.com) or by calling 1-844-598-7543. 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.mygilsbar.com](http://www.mygilsbar.com) or call 1-844-598-7543 to request a copy. |

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| --- | --- | --- | --- |
| **Important Questions** | | **Answers** | **Why this Matters:** |
| **What is the overall deductible?** | | **$750** person / **$2,250** family | 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 services covered before you meet your deductible?** | | Yes. Preventive care services are covered before you meet 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 don’t have to meet deductibles for specific services. |
| **What is the out–of–pocket limit for this plan?** | | **$4,000** person / **$8,000** family In-network  **$8,000** person / **$16,000** family Out-of-network | The out-of-pocket limitis the most you could pay in a year for covered services.  If you have other family members in this plan, they have to 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?** | | Penalties, premiums, balance billing charges, 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.mygilsbar.com](http://www.mygilsbar.com) or call  1-844-598-7543 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. | You can see the specialist you choose without a referral. |
| **Description: Exclamation** | All copaymentand 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** |
| --- | --- | --- | --- | --- |
| **In-network**  **(You will pay the least)** | **Out-of-network**  **(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 | $30 Copay per visit;  Deductible Waived | 40% Coinsurance | None |
| Specialist visit | $45 Copay per visit;  Deductible Waived | 40% Coinsurance | None |
| Preventive care/screening/ immunization | No charge;  Deductible Waived | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test  (x-ray, blood work) | $30 Copay per visit PCP;  $45 Copay per visit Specialist; Deductible Waived office setting; 20% Coinsurance outpatient setting | 40% Coinsurance | None |
| Imaging  (CT/PET scans, MRIs) | 20% Coinsurance | 40% Coinsurance | None |
| **If you need drugs to treat your illness or condition.**  More information aboutprescription drug coverageis available at www.express-scripts.com. | Generic drugs (Tier 1) | Retail: $15 copay/prescription  Mail order: $30 copay/prescription | Not covered | Covers up to a 30-day supply (retail pharmacy); 90-day supply (mail order pharmacy). Specialty drugs are only available in a 30-day supply through the specialty drugs pharmacy and may require prior authorization and be subject to quantity limits.  Preventive medication and contraceptives are covered at no charge as required by law.  Brand-name drug penalty: If your physician authorizes generic but you choose brand name, you pay the actual cost difference plus the brand name copayment.  Deductible does not apply to prescription drug expenses with copayments. |
| Preferred brand drugs (Tier 2) | Retail: $40 copay/prescription  Mail order: $80 copay/prescription | Not covered |
| Non-preferred brand drugs (Tier 3) | Retail: $70 copay/prescription  Mail order: $140 copay/prescription | Not covered |
| Specialty drugs (Tier 4) | 10% of the cost of the drug up to a $150 maximum copay/prescription | Not covered |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | 40% Coinsurance | None |
| Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 20% Coinsurance | 20% Coinsurance | In-network deductible applies to  Out-of-network benefits |
| Emergency medical transportation | 20% Coinsurance | 20% Coinsurance | In-network deductible applies to  Out-of-network benefits |
| Urgent care | $30 Copay per visit;  Deductible Waived | 40% Coinsurance | None |
| **If you have a hospital stay** | Facility fee  (e.g., hospital room) | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. If you don’t get preauthorization, benefits could be reduced by 50% of the total cost of the service. |
| Physician/surgeon fee | 20% Coinsurance | 40% Coinsurance |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | $30 Copay per visit;  Deductible Waived office visits; 20% Coinsurance other outpatient services | 40% Coinsurance | None |
| Inpatient services | 20% Coinsurance | 40% Coinsurance | Preauthorization is required. If you don’t get preauthorization, benefits could be reduced by 50% of the total cost of the service. |
| **If you are pregnant** | Office visits | No charge;  Deductible Waived | 40% Coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| Childbirth/delivery professional services | 20% Coinsurance | 40% Coinsurance |
| Childbirth/delivery facility services | 20% Coinsurance | 40% Coinsurance |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coinsurance | 40% Coinsurance | 60 Maximum visits per calendar year; Preauthorization is required. |
| Rehabilitation services | 20% Coinsurance | 40% Coinsurance | Preauthorization is required for ST.  If your plan excludes Learning Disabilities, habilitation services for learning disabilities are not covered, please refer to your plan document. |
| Habilitation services | 20% Coinsurance | 40% Coinsurance |
| Skilled nursing care | 50% Coinsurance | 50% Coinsurance | 60 Maximum days per calendar year; Preauthorization is required. If you don’t get preauthorization, benefits could be reduced by 50% of the total cost of the service. |
| Durable medical equipment | 20% Coinsurance | 40% Coinsurance | Preauthorization is required for DME in excess of $5,000 for purchases. |
| Hospice service | 20% Coinsurance | 40% Coinsurance | None |
| **If your child needs dental or eye care** | Children’s eye exam | No charge;  Deductible Waived | Not covered | 1 Maximum exam per calendar year |
| 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 Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)** | | |
| * Acupuncture | * Dental care (Adult) | * Long-term care |
| * Bariatric surgery | * Hearing aids | * Routine foot care |
| * Cosmetic surgery | * Infertility treatment | * Weight loss programs |

|  |  |  |
| --- | --- | --- |
| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)** | | |
| * Chiropractic care | * Private-duty nursing (Outpatient care) | * Routine eye care (Adult) |
| * Non-emergency care when traveling outside the U.S. |  |  |

**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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://www.HealthCare.gov). 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 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://www.HealthCare.gov). Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at [www.HealthCare.gov](http://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 Standard? 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.

***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.

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

**Peg is Having a Baby**(9 months of in-network pre-natal care and a hospital delivery)

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

**◼ The plan's overall deductible $750**

**◼ Specialist copayment $45**

**◼ Hospital (facility) coinsurance 20%**

**◼ Other coinsurance 20%**

**This EXAMPLE event includes services like:**

Specialist office visits *(pre-natal 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 | $750 |
| Copayments | $200 |
| Coinsurance | $1,800 |
| *What isn’t covered* | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | **$2,820** |

**◼ The plan's overall deductible $750**

**◼ Specialist copayment $45**

**◼ Hospital (facility) coinsurance 20%**

**◼ Other coinsurance 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)*

|  |  |
| --- | --- |
| **Total Example Cost** | **$5,600** |

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

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles\* | $200 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn’t covered* | |
| Limits or exclusions | $4,400 |
| **The total Joe would pay is** | **$4,800** |

**◼ The plan's overall deductible $750**

**◼ Specialist copayment $45**

**◼ Hospital (facility) coinsurance 20%**

**◼ Other coinsurance 20%**

**This EXAMPLE event includes services like:**

Emergency room care *(including medical supplies)*

Diagnostic tests *(x-ray)*

Durable medical equipment *(crutches)*

Rehabilitation services *(physical therapy)*

|  |  |
| --- | --- |
| **Total Example Cost** | **$2,800** |

**In this example, Mia would pay:**

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles\* | $750 |
| Copayments | $30 |
| Coinsurance | $400 |
| *What isn’t covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | **$1,190** |

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: [www.mygilsbar.com](http://www.mygilsbar.com) or call 1-844-598-7543.

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?”" row above.