




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 your Human Resources department. 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.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall plan year deductible ?	For network providers \$1,500 Individual / \$4,500 Family; For out-of-network providers \$4,500 Individual / \$13,500 Family	Generally, you must pay all of the costs from providers up to the calendar year 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 and primary 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 plan year out-of-pocket limit for this plan ?	For network providers \$6,000 Individual / \$12,000 Family For out-of-network providers \$18,000 Individual / \$36,000 Family	The out-of-pocket limit is the most you could pay in a calendar 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 ?	Premiums , balanced-billed charges , copayments , amounts over Usual and Customary fees and health care this plan does not 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 ?	See consociate.veriben.net or call 1-800-798-2422 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 .

 All [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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copayment	50% coinsurance	For Network Providers: Allergy injections are included in Office Visit copayment . If no Office Visit then copayment applies.
	Specialist visit	\$40 copayment	50% coinsurance	
	Preventive care/screening/immunization	No Charge	No Charge	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	For Network Providers, diagnostic tests are included in Office Visit copayment .
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.empirxhealth.com	Generic drugs	Retail 30-day supply: \$8 copayment Retail or Mail Order 90-day supply: \$20 copayment	Not Covered	Covers up to a 90-day supply (retail); 90-day supply (mail order).
	Preferred brand drugs	Retail 30-day supply: \$40 copayment Retail or Mail Order 90-day supply: \$120 copayment		
	Non-preferred brand drugs	Retail 30-day supply: \$80 copayment Retail or Mail Order 90-day supply: \$240 copayment		
	Specialty drugs	25% coinsurance to a maximum of \$350 per prescription, deductible does not apply	Not Covered	Specialty drugs can only be filled by mail order pharmacy - Benecard Central Fill. Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	* Emergency room Facility/Physician: \$300 copayment after Network deductible . * Emergency room Mental Health/Substance Abuse Physician services: \$20 copayment , after Network deductible .		Preauthorization is required if admitted. Copay waived if admitted.
	Emergency medical transportation	20% coinsurance after Network deductible		Non-emergency Ambulance Services not covered.
	Urgent care	\$50 copayment	50% coinsurance	None

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

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 you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required or benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required or benefits could be reduced.
If you are pregnant	Office visits	\$20 copayment	50% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Not covered for dependent daughter. Preauthorization is required for some maternity hospital stays.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 100 visits per plan year.
	Rehabilitation services	Office Visit: \$20 copayment Outpatient Services:	50% coinsurance	Physical, Occupational, and Speech Therapies are limited to a combined visit limit of 60 each per plan year.
	Habilitation services	20% coinsurance	50% coinsurance	
	Chiropractic Services	50% coinsurance , deductible does not apply	Not Covered	Chiropractic limited to 26 visits per plan year.
	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization is required. Coverage is limited to 150 days per plan year.
	Pulmonary Rehabilitation	Office Visit: \$40 copayment Outpatient Services: 20% coinsurance	50% coinsurance	Limited to 20 visits per plan year.
	Cardiac Rehabilitation	Office Visit: \$40 copayment Outpatient Services: 20% coinsurance	50% coinsurance	Limited to 36 visits per plan year.
	Durable medical equipment	50% coinsurance	50% coinsurance	None
Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required if inpatient services.	
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	None
	Children's glasses	Not Covered		None
	Children's dental check-up	Not Covered		None

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

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](#).)

- Acupuncture
- Hearing Aids (covered if medically necessary)
- Routine eye care
- Cosmetic surgery
- Long-term care
- Routine foot care, except for diabetics
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- 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 (limited to 26 visit limit per plan year, for In-Network only)
- Private-duty nursing (limited to 60 visits)

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: Consociate Health: 1-800-798-2422. 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 x 61565 or www.cciio.cms.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 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: Consociate Health: 1-800-798-2422

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:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-798-2422

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-798-2422

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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](#) \$1,500
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$40
Coinsurance	\$2,230
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,770

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$40
- 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$40
Coinsurance	\$810
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,350

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$340
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$340
Coinsurance	\$190
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,030

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.