

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, go to www.detegohealth.com or call 1-866-815-6001 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.

The Annual Maximum for this policy is limited to \$40,000.00 per Benefit Period.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	None	There is no deductible for this plan.
Are there services covered before you meet your deductible ?	Yes	There is no deductible for this plan.
Are there other deductibles for specific services?	None	There is no deductible for this plan.
What is the out-of-pocket limit for this plan ?	None	There is no out-of-pocket for this plan.
What is not included in the out-of-pocket limit ?	Not applicable	There is no out-of-pocket for this plan.
Will you pay less if you use a network provider ?	No network restrictions.	There are no network restrictions for this plan.
Do you need a referral to see a specialist ?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

Common Medical Event	Services You May Need	Member out of pocket	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 6 for Employee Tier 12 for Family Tier	\$20 copay/visit	Subject to plan allowable
	<u>Specialist</u> visit 6 for Employee Tier 12 for Family Tier	\$40 copay/visit	Subject to plan allowable
	<u>Preventive care/screening/immunization</u>	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Services are limited to those covered by the Affordable Care Act. Annual physical not available until 9 months after effective date. All services must be conducted in office, hospital services are not covered.
	Tele-Medicine	\$5 copay/visit	Unlimited
If you have a test	<u>Diagnostic test</u> (X-ray and blood work) 6 for Employee Tier 12 for Family Tier	\$60 copay per visit	Subject to plan allowable
	Imaging (CT/PET scans, MRIs) 2 per Benefit Period If Green Imaging is used Up to 5 Per Benefit Period	\$150 copay per visit	Subject to plan allowable
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at myfreepharmacy.com	Generic drugs	\$0 Copay	All drugs are through our Precision RX Program Formulary Only
	<u>Specialty drugs</u>	No Coverage	None (Only covered through Patient Assistance Program)

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

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery. Claims Control Pro will assist you with balance bills. Email memberservices@detegohealth.com	<u>Ambulatory Surgical Center</u> 1 Per Employee/ Per Benefit Period 2 Per Family/ Per Benefit Period	\$500 Copay/Per surgery	Subject to plan allowable. Capped at \$2,500 per Surgery
	<u>Outpatient Hospital Surgery</u> 1 Per Employee/ Per Benefit Period 2 Per Family/ Per Benefit Period	\$500 copay/surgery	Subject to plan allowable. Capped at \$2,500 per Surgery
	<u>Outpatient Hospital Facility Charge</u> 1 Per Employee/ Per Benefit Period 2 Per Family/ Per Benefit Period	\$500 Copay/Per surgery	Subject to plan allowable. Capped at \$2,500 per Surgery
	<u>Physician/surgeon fees</u> 1 Per Employee/ Per Benefit Period 2 Per Family/ Per Benefit Period	\$500 copay/visit	Subject to plan allowable. Capped at \$2,500 per Surgery
If you need immediate medical attention	<u>Emergency room care</u> 2 Per Benefit Period	\$350 copay/visit	Subject to plan allowable. Copayment waived if admitted.
	<u>Emergency medical transportation</u> 2 Per Benefit Period	\$500 copay/transport	Capped at \$1,000 Subject to plan allowable
	<u>Urgent care</u> 3 Per Employee/ Per Benefit Period 6 Per Family/ Per Benefit Period	\$60 copay/visit	Subject to plan allowable
If you have a hospital stay. Claims Control Pro will assist you with balance bills. Email memberservices@detegohealth.com	<u>Facility fee (e.g., hospital room)</u> 6 days per benefit period	\$150 copay/day limited to \$750 per day	Subject to plan allowable
	<u>Inpatient Surgery</u> 1 Per Employee Per Benefit Period 2 Per Family Per Benefit Period	\$500 copay/stay	Capped at \$2,500 per surgery. Subject to plan allowable.
	<u>Physician/surgeon fees</u> 1 Per Employee Per Benefit Period 2 Per Family Per Benefit Period	\$500 copay/visit	Capped at \$2,500 per Surgery. Subject to plan allowable

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Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
	Inpatient rehabilitation	No Coverage	None
If you need mental health, behavioral health and substance abuse services	Outpatient services	No Coverage	None
	<u>Inpatient services</u> 4 days per benefit period	\$60 copay/day	Subject to plan allowable
If you are pregnant. Claims Control Pro will assist you with balance bills. Email memberservices@detegohealth.com	Office visits	No Charge	Subject to plan allowable
	Childbirth/delivery professional services	\$500 copay/visit	Subject to plan allowable
	<u>Childbirth/delivery facility services</u> 5 days per benefit period	\$150 copay/day, limited to \$750 per day.	Subject to plan allowable
If you need help recovering or have other special health needs	<u>Home health care</u>	No Coverage	None
	<u>Chiropractic services</u> 12 per benefit period	\$60 copay/visit	Subject to plan allowable
	Habilitation services	No Coverage	None
	Skilled nursing care	No Coverage	None
	Durable medical equipment	25% Coinsurance	Capped at \$1,000 Per Benefit Period, subject to plan allowable
	Hospice services	No Coverage	None
If your child needs dental or eye care	Children's eye exam	No charge	1 exam/member/benefit period.
	Children's glasses	No charge	40% off.
	Children's dental check-up	No charge	Subject to plan allowable

[* For more information about limitations and exceptions, see the plan or policy document at www.detegohealth.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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Durable Medical Equipment
- Infertility treatments
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Chiropractic Care
- Diagnostic Testing
- Emergency Room Visits
- Inpatient/Outpatient Surgery
- PCP/Specialist Office Visits
- Prescriptions
- Urgent Care 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: 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: Detego 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

Does this plan provide Minimum Essential Coverage? **Yes**

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. **The Annual Maximum for this policy is limited to \$40,000.00 per Benefit Period.**

Does this plan meet the Minimum Value Standards? **No**

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]

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 [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] \$0
- Hospital (facility) [*cost sharing*] \$150
- Other [*cost sharing*] \$500

This EXAMPLE event includes services like:

Primary care 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:

<i>Cost Sharing</i>	
Deductibles	\$0.00
Copayments	\$750
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$750

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] \$40
- Hospital (facility) [*cost sharing*] 0%
- Other [*cost sharing*] \$60/20

This EXAMPLE event includes services like:

Primary care office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)
Limited to \$1000 Per Benefit Period

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$360
Coinsurance	\$250
<i>What isn't covered</i>	
Limits or exclusions (Durable Medical Equipment)	\$200
The total Joe would pay is	\$810

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] \$40
- Hospital (facility) [*cost sharing*] \$350
- Other [*cost sharing*] \$60

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*) **25%**
Coinsurance up to \$1000
 Rehabilitation services (*physical therapy*) **Not covered \$400**

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$620
Coinsurance	\$250
<i>What isn't covered</i>	
Limits or exclusions	\$350
The total Mia would pay is	\$1,220