



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

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$3,500/individual or \$7,000/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, but see chart starting on page 2 for other costs for services this plan covers. |
| What is the out-of-pocket limit for this plan ? | \$6,550/individual or \$13,100/family | 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 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-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 ? | No network restrictions. | |
| Do you need a referral to see a specialist ? | No. You don't 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 | 20% after deductible | Subject to plan allowable |
| | Specialist visit | 20% after deductible | Subject to plan allowable |
| | Preventive care/screening/immunization | 0% coinsurance | 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> . Then check what your <u>plan</u> will pay for. Subject to plan allowable |
| If you have a test | Diagnostic test (blood work) | 20% after deductible | Subject to plan allowable |
| | Imaging (X-Ray, CT/PET scans, MRIs) | 20% after deductible | Subject to plan allowable |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medalistrx.com | Generic drugs | \$10 co-pay after deductible | <u>Copays</u> listed are for 0-30 day supply/prescription. 31-90 day supply; generic \$30.00 co-pay after deductible, brand name \$90.00 co-pay after deductible, Non-Preferred Brand \$150.00 co-pay after deductible |
| | Preferred brand drugs | \$45 co-pay after deductible | |
| | Non-preferred brand drugs | \$85 co-pay after deductible | |
| | Specialty drugs | Excluded | Excluded |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% after deductible | Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable. |
| | Physician/surgeon fees | 20% after deductible | Subject to plan allowable |
| If you need immediate medical attention | Emergency room care | 20% after deductible | Subject to plan allowable |
| | Emergency medical transportation | 20% after deductible | 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 | Member out of pocket | Limitations, Exceptions, & Other Important Information |
|--|---|----------------------|---|
| | Urgent care | 20% after deductible | Subject to plan allowable |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% after deductible | Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable. |
| | Physician/surgeon fees | 20% after deductible | Subject to plan allowable |
| If you need mental health, behavioral health and substance abuse services | Outpatient services | 20% after deductible | Subject to plan allowable |
| | Inpatient services | 20% after deductible | Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable. |
| If you are pregnant | Office visits | 20% after deductible | Subject to plan allowable |
| | Childbirth/delivery professional services | 20% after deductible | Subject to plan allowable |
| | Childbirth/delivery facility services | 20% after deductible | Subject to plan allowable |
| If you need help recovering or have other special health needs | Home health care | 20% after deductible | Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable. |
| | Rehabilitation services | 20% after deductible | Limited to 20 visits per Calendar Year for physical, and occupational therapies each, 20 visits for Speech, 15 visits for Chiropractic. Subject to plan allowable |
| | Habilitation services | 20% after deductible | Limited to 20 visits per Calendar Year, combined with the above therapies. Subject to plan allowable |
| | Skilled nursing care | 20% after deductible | Limited to 60 days per Calendar Year. Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable |
| | Durable medical equipment | 20% after deductible | Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). 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 | Member out of pocket | Limitations, Exceptions, & Other Important Information |
|---|----------------------------------|----------------------|---|
| | | | (Limited to 12 month rental or purchase price, whichever is less) |
| | Hospice services | 20% after deductible | Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). Subject to plan allowable. |
| If your child needs dental or eye care | Children's eye exam | Not covered | None |
| | Children's glasses | Not covered | None |
| | Children's dental check-up | Not covered | None |

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 Bariatric surgery 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 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.) | |
|--|---|
| <ul style="list-style-type: none"> Chiropractic Care | <ul style="list-style-type: none"> Durable medical equipment |

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.

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 [877-585-8480]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [877-585-8480]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[877-585-8480]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [877-585-8480]

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 [plan's](#) overall [deductible](#) \$3,500
- [Specialist \[coinsurance\]](#) 20%
- [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 | \$7,580 |
|---------------------------|----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,500 |
| Copayments | \$0 |
| Coinsurance | \$816 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$4,316 |

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist \[coinsurance\]](#) 20%
- [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 | \$1,000 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,000 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,000 |

Mia's Simple Fracture

(emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist \[coinsurance\]](#) 20%
- [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 | \$3,500 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,500 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$3,500 |