
 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, www.40Square.coop. 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 or call 877-314-9737 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For Network providers : \$6,550/Individual or \$13,100/family For Non-network providers : \$10,000/Individual or \$20,000/family	Generally, you must pay all of 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 ?	For Network providers : \$6,750/Individual or \$13,500/family For Non-network providers : \$30,000/Individual or \$60,000/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 ?	<u>Penalties for non-compliance with plan provisions; premiums, balance-billing charges, and health care this plan doesn't cover.</u>	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 https://www.preferredone.com/ or www.multiplan.com 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 [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
		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	30% coinsurance	50% coinsurance	Out-of-network chiropractic care is paid as network.
	Specialist visit	30% coinsurance	50% coinsurance	None
	Preventive care/screening/immunization	No charge	50% coinsurance	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% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.medtrakrx.com	Generic drugs (Tier 1)	30% coinsurance	Paid as network	Covers up to a 31-day supply (retail); 90 day supply (mail order/Performance 90 pharmacy). Certain contraceptives are covered at no charge.
	Preferred brand drugs (Tier 2)	30% coinsurance	Paid as network	
	Non-preferred brand drugs (Tier 3)	30% coinsurance	Paid as network	
	Specialty drugs (Tier 4)	30% coinsurance	Paid as network	Preventive Drugs (contact the Rx vendor for a list of Preventive Drugs): Generic - \$10 (31 day - retail) / \$25 (90 day - mail order/Performance 90 pharmacy) Formulary brand - \$40 (31 day - retail) / \$100 (90 day - mail order/Performance 90 pharmacy) Non-Formulary Brand - \$100 (31 day - retail) / \$250 (90 day - mail order/Performance 90 pharmacy)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service up to a maximum of \$500.

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)	
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	Paid as network.	None
	Urgent care	30% coinsurance	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service up to a maximum of \$500.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service up to a maximum of \$500.
	Inpatient services	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	30% coinsurance	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).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	120 visits/ calendar year
	Rehabilitation services	30% coinsurance	50% coinsurance	None
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	120 visits/calendar year
	Durable medical equipment	30% coinsurance	50% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service up to a maximum of \$500.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to one per year
	Children's glasses	Not covered	Not covered	Not covered

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)	
	Children's dental check-up	Not covered	Not covered	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](#).)

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|---|---|---|
| <ul style="list-style-type: none"> • Bariatric Surgery • Cosmetic Surgery • Dental Care except for certain oral surgeries or treatment to sound natural teeth required when due to injury. | <ul style="list-style-type: none"> • Infertility Treatment • Long Term Care • Private Duty Nursing | <ul style="list-style-type: none"> • Routine Foot Care • Weight Loss Programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none"> • Acupuncture • Chiropractic Care • Hearing Aids | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. unless the Plan Member traveled outside of the U.S. for purpose of obtaining medical services, supplies, or drugs. | <ul style="list-style-type: none"> • Routine eye care (Adult) |
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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 1-866-444-3272 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 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 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 877-314-9737.

----- *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](#) \$6,550
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$6,550
Copayments	\$0
Coinsurance	\$250
<i>What isn't covered</i>	
Limits or exclusions	\$2,010
The total Peg would pay is	\$8,760

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

- The [plan's](#) overall [deductible](#) \$6,550
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,090
Copayments	\$1,810
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,960

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

- The [plan's](#) overall [deductible](#) \$6,550
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900