**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, call 1-844-234-4472. 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.healthcare.gov/sbc-glossary.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $3,000 person/$6,000 family. Doesn't apply to preventative care. For non-participating providers $6,000 person/ $12,000 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. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| **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 participating providers $7,350 person/ $14,700 family. For non-particpating providers $20,000 person/$40,000 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?** | Premiums, difference between billed and allowed amounts, healthcare this plan doesn't cover, and ineligible expenses. | 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.MotivHealth.com** or call **1-844-234-4472** for a list of participating 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 | $40/visit | 50% After Deductible | |
| | Specialist visit | $80/visit | 50% After Deductible | |
| | Preventive care/ screening/immunization | No charge | No charge up to allowed amount | 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) | Included in office copay | 50% After Deductible | |
| | Imaging (CT/PET scans, MRIs) | 20% After Deductible | 50% After Deductible | Prior authorization applies |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at www.motivhealth.com | Generic drugs | $20/prescription | Not covered | $20 for 1-30 day supply/$50 for 31-90 day supply |
| | Preferred brand drugs | $50/prescription | Not covered | $50 for 1-30 day supply/$125 for 31-90 day supply |
| | Non-preferred brand drugs | $80/prescription | Not covered | $80 for 1-30 day supply/$200 for 31-90 day supply |
| | Specialty drugs | 20% After Deductible | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% After Deductible | 50% After Deductible | |
| | Physician/surgeon fees | 20% After Deductible | 50% After Deductible | |
| **If you need immediate medical attention** | Emergency room care | $500/visit | $500/visit | Out-of-network utilization of these benefits will apply to in network benefits up to allowed amount |
| | Emergency medical transportation | 20% After Deductible | 20% After Deductible | Out-of-network utilization of these benefits will apply to in network benefits up to allowed amount |

| | | | | |
|---|---|---|---|---|
| | Urgent care | $100/visit | 50% After Deductible | |

| 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% After Deductible | 50% After Deductible | Pre-cert is required except for maternity care. |
| | Physician/surgeon fees | 20% After Deductible | 50% After Deductible | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $40/visit | 50% After Deductible | Facility charges require prior authorization. |
| | Inpatient services | 20% After Deductible | 50% After Deductible | |
| **If you are pregnant** | Office visits | $40/visit | 50% After Deductible | |
| | Childbirth/delivery professional services | 20% After Deductible | 50% After Deductible | Home births are not covered. |
| | Childbirth/delivery facility services | 20% After Deductible | 50% After Deductible | Home births are not covered. |
| **If you need help recovering or have other special health needs** | Home health care | 20% After Deductible | 50% After Deductible | |
| | Rehabilitation services | $80/visit | 50% After Deductible | Limited to 20 visits per year |
| | Chiropractic services | $80/visit | 50% After Deductible | Limited to 20 visits per year |
| | Habilitation services | 20% After Deductible | 50% After Deductible | |
| | Skilled nursing care | 20% After Deductible | 50% After Deductible | Limited to 30 days per year |
| | Durable medical equipment | 20% After Deductible | 50% After Deductible | |
| | Hospice services | 20% After Deductible | 50% After Deductible | |
| **If you need eye care** | Eye exam | No charge | 50% After Deductible | Limited to one exam per year. |
| | Children's glasses | 20% After Deductible | 50% After Deductible | Limited to one pair of glasses per year. Benefit not to exceed $150. |

## 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
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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 limited to 20 visits per year |

**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 the Department of Labor's Employee Benefits Security Administration is 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 1-801-318-2596.

**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 MotivHealth at 1-844-234-4472 or the 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**

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 1-844-234-4472.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-234-4472.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-234-4472.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-234-4472.]

*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 | $3,000 |
| Specialist | $80 |
| Hospital (facility) | 20% |
| Other | 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** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,000 |
| Copayments | $0 |
| Coinsurance | $1,940 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$4,900** |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist | $80 |
| Hospital (facility) | 20% |
| Other | 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 | $3,000 |
| Copayments | $0 |
| Coinsurance | $520 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$3,500** |

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

| | |
|---|---|
| The plan's overall deductible | $3,000 |
| Specialist | $80 |
| Hospital (facility) | 20% |
| Other | 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** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,800 |
| Copayments | $80 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,900** |

The plan would be responsible for the other costs of these EXAMPLE covered services.