
 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 800-457-4726. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-844-855-0614 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers : \$0 person / \$0 family; for out-of-network providers \$500 person or \$1,000 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 \$1,850 person / \$12,700 family; for out-of-network providers Unlimited	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 , balance-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 ?	Yes. See www.andrustransbenefits.com or call 800-457-4726 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 don't have to obtain a referral to see a specialist .

 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	\$15 copay	40% coinsurance	Deductible does not apply copay
	Specialist visit	\$25 copay / visit	40% coinsurance	Deductible does not apply copay
	Preventive care/screening/immunization	No charge	40% coinsurance	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)	\$50 copay	40% coinsurance	Diagnostic test associated with office visits are covered at no charge.
	Imaging (CT/PET scans, MRIs)	\$400 copay	40% coinsurance	None .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.AndrusBenefits.com	Generic drugs (Tier 1)	\$25 copay (retail) / \$50 copay (mail order)	Not Covered	Copay applies per prescription. Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). No charge for ACA mandated preventive drugs and smoking deterrents.
	Preferred brand drugs (Tier 2)	\$60 copay (retail) / \$120 copay (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	\$125 copay (retail) / \$250 copay (mail order)	Not Covered	
	Specialty drugs (Tier 4)	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	None
	Physician/surgeon fees	Not Covered	Not Covered	
If you need immediate medical attention	Emergency room care	\$400 copay	40% coinsurance	Deductible does not apply copay . True emergency covered at in-network level
	Emergency medical transportation	Not Covered	Not Covered	None
	Urgent care	\$50 copay per visit	40% coinsurance	Deductible does not apply copay .
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	None
	Physician/surgeon fees	Not Covered	Not Covered	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.andrustransbenefits.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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay / visit	40% coinsurance	Deductible does not apply copay .
	Inpatient services	Not Covered	Not Covered	None.
If you are pregnant	Office visits	No Charge	40% coinsurance	Cost-sharing does not apply to preventive services from a participating provider. Depending on the type of services, a copay and/or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Not Covered	Not Covered	
	Childbirth/delivery facility services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	None
	Rehabilitation services	Not Covered	Not Covered	None
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Not Covered	Not Covered	None
	Durable medical equipment	Not Covered	Not Covered	None
	Hospice services	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	Coverage limited to one exam/year.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	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 & child) 	<ul style="list-style-type: none"> Hearing Aids Long Term Care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Private Duty Nursing (except for home health care & hospice) Routine Foot Care Weight Loss Programs

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Routine eye Care (1 exam per year)
- Routine Foot Care
- Emergency care when traveling outside the U.S.
- Chiropractic Care

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <https://www.dol.gov/agencies/ebsa>. 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:

The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <https://www.dol.gov/agencies/ebsa>

Does this plan provide Minimum Essential Coverage? No.

[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 800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-378-1179.

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](#) \$0
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) N/A
- Other [coinsurance](#) N/A

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$990
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$11,410
The total Peg would pay is	\$12,400

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) N/A
- Other [coinsurance](#) N/A

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,760
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,780
The total Joe would pay is	\$3,540

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) N/A
- Other [coinsurance](#) N/A

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$130
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$1,040
The total Mia would pay is	\$1,250

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