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, visit www.dgb-online.com or call **1-888-322-2524** ext. 412. 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.dgb-online.com or call 1-888-322-2524 ext. 412 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Hospital Facilities, Ambulatory Health Care Centers & PPO Providers **$1,000** person/**$2,000** family Non-PPO Providers **$2,000** person/**$5,000** family All deductibles are per calendar year.	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. PPO Preventive care services and PPO Prenatal/Preconception care 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?	Hospital Facilities, Ambulatory Health Care Centers, & PPO Providers **$6,500** person/**$13,000** family Non-PPO Providers **$10,500** person/**$26,250** family Medical and Prescription copays, deductible and coinsurance track to the out-of-pocket limit per calendar year.	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, pre-authorization penalties, 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, PHCS (for Physician and non-facility providers only). See www.multiplan.com/phcspracanc or call **1-877-952-7427** for a list of preferred 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see a 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	$15 copay/visit* Includes Office Surgery	30% coinsurance*	Hospital Facilities and Ambulatory Health Care Centers paid as PPO up to Allowable Claim Limits. Preauthorization is required for Office Surgery which exceeds $1,000. If you don't get preauthorization, there is a $250 penalty. TelaDoc: No charge; deductible and copay do not apply.
	Specialist visit	$25 copay/visit* Includes Office Surgery	30% coinsurance*	Hospital Facilities and Ambulatory Health Care Centers paid as PPO up to Allowable Claim Limits. Preauthorization is required for Office Surgery which exceeds $1,000. If you don't get preauthorization, there is a $250 penalty. Chiropractic care 30 visits per calendar year. TMJ (non-surgical) 5 visits per calendar year.
	Preventive care/screening/ immunization	No charge; deductible does not apply	30% 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. Hospital Facilities and Ambulatory Health Care Centers paid as PPO up to Allowable Claim Limits. Colonoscopies are not covered from a non-participating provider.

***After Deductible**

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 have a test	Diagnostic test (x-ray, blood work)	No charge*	30% coinsurance*	Hospital Facilities and Ambulatory Health Care Centers paid as PPO up to Allowable Claim Limits.
	Imaging (CT/PET scans, MRIs)	No charge*	30% coinsurance*	Hospital Facilities and Ambulatory Health Care Centers paid as PPO up to Allowable Claim Limits. Preauthorization is required. If you don't get preauthorization, there is a $250 penalty.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empirxhealth.com	Generic drugs	$15 copay/prescription (retail); deductible does not apply $30 copay/prescription (mail); deductible does not apply	30% coinsurance*	Covers 90-day supply retail prescription (3 retail copays apply).
	Preferred brand drugs	$25 copay/prescription (retail); deductible does not apply $50 copay/prescription (mail); deductible does not apply	30% coinsurance*	
	Non-preferred brand drugs	$40 copay/prescription (retail); deductible does not apply $80 copay/prescription (mail); deductible does not apply	30% coinsurance*	
	Specialty/Biotech drugs	$500 copay/prescription; deductible does not apply	30% coinsurance*	Preauthorization is required. If you don't get preauthorization, there will be no coverage. Covers up to a 30-day supply. Approved international pharmacy, including PriceMDs program: No charge; copay and deductible do not apply.

***After Deductible**

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit* up to allowable claim limit under the Claim Review & Audit Program. PPO deductible applies.		Preauthorization is required. If you don't get preauthorization, there is a $250 penalty.
	Physician/surgeon fees	No charge*	30% coinsurance*	
If you need immediate medical attention	Emergency room care	$150 copay/visit* up to allowable claim limit under the Claim Review & Audit Program. PPO deductible applies.		Copay waived if admitted. Services for a Non-Emergency Medical Condition are not covered.
	Emergency medical transportation	No charge*	No charge after PPO deductible	Professional local ambulance to and from nearest hospital. Services for a Non-Emergency Medical Condition are not covered. Hospital Facilities and Ambulatory Health Care Centers paid as PPO up to Allowable Claim Limits.
	Urgent care	$45 copay/visit*	30% coinsurance*	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/day* (max of $2,000 per admission) up to allowable claim limit under the Claim Review & Audit Program. PPO deductible applies.		Preauthorization is required. If you don't get preauthorization, there is a $250 penalty.
	Physician/surgeon fees	No charge*	30% coinsurance*	

***After Deductible**

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 need mental health, behavioral health, or substance abuse services	Physician services	Office visits: $15 copay/visit* Hospital visits: No charge*	30% coinsurance*	Hospital Facilities and Ambulatory Health Care Centers paid as PPO up to Allowable Claim Limits.
	Inpatient services	$500 copay/day* (max of $2,000 per admission) up to allowable claim limit under the Claim Review & Audit Program. PPO deductible applies.		Preauthorization is required. If you don't get preauthorization, there is a $250 penalty.
	Partial Hospitalization	$15 copay/visit* up to allowable claim limit under the Claim Review & Audit Program. PPO deductible applies.		None
If you are pregnant	Office visits	Prenatal/Preconception: No charge; deductible does not apply Postnatal: No charge*	Prenatal/Preconception: 30% coinsurance* Postnatal: 30% coinsurance*	Hospital Facilities and Ambulatory Health Care Centers paid as PPO up to Allowable Claim Limits.
	Childbirth/delivery professional services	No charge*	30% coinsurance*	Preauthorization is required if stay exceeds 48 hours normal delivery/96 hours cesarean. If you don't get preauthorization, there is a $250 penalty.
	Childbirth/delivery facility services	$500 copay/day* (max of $2,000 per admission) up to allowable claim limit under the Claim Review & Audit Program. PPO deductible applies.		

***After Deductible**

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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care		$15 copay/visit*	30% coinsurance*	80 visits per calendar year. Preauthorization is required. If you don't get preauthorization, there is a $250 penalty.
	Rehabilitation services		$25 copay/visit*	30% coinsurance*	Physical, Speech and Occupational Therapy 40 visits combined per calendar year. Hospital Facilities and Ambulatory Health Care Centers paid as PPO up to Allowable Claim Limits. Developmental delay, education & training excluded.
	Habilitation services				
	Skilled nursing care		$500 copay/day* (max of $2,000 per admission) up to allowable claim limit under the Claim Review & Audit Program. PPO deductible applies.		Skilled Nursing Facility 30 days per calendar year. Extended Care/Rehabilitation facility 60 days per condition. Preauthorization is required. If you don't get preauthorization, there is a $250 penalty.
	Durable medical equipment		No charge*	30% coinsurance*	Preauthorization is required for specialized DME which exceeds $1,500. If you don't get preauthorization, there is a $250 penalty.
	Hospice services	Inpatient	$500 copay/day* (max of $2,000 per admission) up to allowable claim limit under the Claim Review & Audit Program. PPO deductible applies.		None
		Outpatient/Home	No charge*	30% coinsurance*	
If your child needs dental or eye care	Children's eye exam		No charge; deductible does not apply	30% coinsurance*	1 exam per calendar year.
	Children's glasses		Not covered	Not covered	None
	Children's dental check-up		Not covered	Not covered	None

***After Deductible**

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	• Dental Care	• Routine Foot Care
• Cosmetic Surgery	• Long-Term Care	• Weight Loss Programs
	• Private Duty Nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery (limited procedures)	• Infertility Treatment ($5,000 maximum per calendar year)	• Most non-elective services provided outside the United States
• Chiropractic Care (30 visits per calendar year)		• Routine Eye Care
• Hearing Aids (1 per ear every 24 months)		

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: 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 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.

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** **$1,000**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$500/day**
- **Other coinsurance** **0%**

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	$1,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$500/day**
- **Other coinsurance** **0%**

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	$1,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,500**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$500/day**
- **Other coinsurance** **0%**

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	$1,000
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

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