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, contact Aither Health at 1-833-370-9235. 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 1-833-370-9235 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In Network:** Individual: $5,000 Family: $12,700 **Out-Of-Network:** Individual: $6,000 Family: $18,700	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. Deductible accumulations are per plan year.
Are there services covered before you meet your deductible?	Yes. Preventive care services and all categories with a copayment 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/. The deductible is waived if navigated to and seen by a Preferred Tier provider. To optimize your plan benefits and minimize your cost, contact your team of Advocates at 833.370.9235.
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?	**In Network:** Individual: $6,000 Family: $12,700 **Out-Of-Network:** Individual: Unlimited Family: Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met. Accumulations are per plan year.
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.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

* For more information about limitations and exceptions, see the plan or policy document at https://www.aitherhealth.com/members/

Important Questions	Answers	Why This Matters:
		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. This plan encourages members to notify Aither Health at 1-833-370-9235 before receiving any non-emergent specialty care.

All **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
		In Network (You will pay the least)	Out Of Network (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	$10 copayment/visit, deductible does not apply	50% coinsurance	None
	Specialist visit	$80 copayment/visit, deductible does not apply	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 needed 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	To optimize your plan benefits and minimize your cost, contact your team of Advocates at 833.370.9235 before scheduling hospital services, outpatient surgery, diagnostic imaging, or specialist visits. Preauthorization is required for complex imaging.
	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	Preferred generic drugs	$1 copayment/visit, deductible does not apply	Not Covered	Cost based on a 30-day supply. Cost for up to a 90-day supply is tripled. If you purchase a brand-name drug when a generic equivalent is available, you will pay the generic copayment, plus the difference in cost between the brand and the generic. Except
	Preferred brand drugs	$35 copayment/visit, deductible does not apply	Not Covered	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out Of Network (You will pay the most)	
www.vividclearrx.com	Non-preferred brand drugs	$75 copayment/visit, deductible does not apply	Not Covered	where prevented by law, certain medications must be coordinated by the plan's Specialty Drug Program. For these drugs, the plan allows one courtesy retail fill. If you choose to continue to fill your Specialty Drug after that one courtesy fill at your retail pharmacy, then you will pay the full price out of pocket and will not be reimbursed by the plan. You will be notified during fulfillment if your medication requires coordination. Specialty drugs are limited to a 30-day supply and will require Preauthorization.
	Specialty drugs	$200 copayment/visit, deductible does not apply	Not Covered	
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, it may result in the denial of otherwise covered services.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Emergency room care covered for true emergencies only.
	Emergency medical transportation	30% coinsurance	30% coinsurance	
	Urgent care	$100 copayment/visit, deductible does not apply	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, it may result in the denial of otherwise covered services.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office Visit	$10 copayment/visit, deductible does not apply	$10 copayment/visit, deductible does not apply	Preauthorization is required for Inpatient services.
	Outpatient services	30% coinsurance	50% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out Of Network (You will pay the most)	
	Inpatient services	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Home birth is only covered in the event of an emergency.
	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	60 visits/year
	Rehabilitation services / Habilitation services (Other than Physical Therapy)	30% coinsurance	50% coinsurance	35 visits/year. Includes physical therapy, speech therapy, and occupational therapy. Preauthorization is required
	Rehabilitation services / Habilitation services (Physical Therapy)	$80 copayment/visit, deductible does not apply	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	25 visits/year
	Durable medical equipment	30% coinsurance	50% coinsurance	Preauthorization is required for purchases greater than $1500 and rentals greater than $500.
	Hospice services	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, it may result in the denial of otherwise covered services.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Covered between the ages of 3-5 years per U.S Preventative guidelines
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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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 (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- 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 (Limit of 18 per plan year)
- Hearing aids ($3000 limit /ear every 2 plan years)
- Infertility treatment (Diagnosis Only)

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: 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 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: 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 833-408-4080

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-408-4080

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 833-408-4080

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833-408-4080

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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	**$5,000**
Specialist copayment	**$80**
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,060**

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

The plan's overall deductible	**$5,000**
Specialist copayment	**$80**
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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$900
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

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

The plan's overall deductible	**$5,000**
Specialist copayment	**$80**
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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$2,100
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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