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 TLC Benefit Solutions, Inc. at 877-949-0940. 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.tlcbenefitsolutions.com or call 877-949-0940 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$800**/Individual or **$2,000**/family in-network providers **$2,500**/Individual or **$0**/family out-of-network providers	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 and primary 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 **$6,850** individual / **$13,700** 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.tlcbenefitsolutions.com or call 877-949-0940 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	$25 copay/office visit and deductible and 20% coinsurance for other outpatient services	50% coinsurance	Coverage is limited to one (1) visit per day.
	Specialist visit	$50 copay/visit	50% coinsurance	Chiropractic services are limited to 20 visits per year. Acupuncture services are limited to 10 visits per year.
	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)	20% coinsurance	50% coinsurance	Prior Authorization may be required
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Prior Authorization may be required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.tlcbenefitsolutions.com	Generic drugs	$15 copay/ prescription (retail order) $45 copay/ prescription (retail 90 network)	Non-Preferred Provider: $25 copay/ 31-day supply	Covers up to a 34-day supply or 90-day (retail prescription); **Disease Management** members pay $10 and $30, respectively (Network Provider). **Diabetes Management** members pay $5 for 34-day supply, at approved Pharmacy stores.
	Preferred brand drugs	$40 copay or 20% coinsurance (Greater Amount)/ prescription (retail order) $120 copay or 20% coinsurance (Greater Amount)/ prescription (retail 90 network)	Non-Preferred Provider: $50 copay or 20% /31-day supply	Covers up to a 34-day supply or 90-day (retail prescription); Therapy Class Restrictions Apply. **Disease Management** members pay $30 (or 20%) and $90 (or 20%), respectively (Network Provider). **Diabetes Management** members pay $5 for 34-day supply, at approved Pharmacy stores.
	Non-preferred brand drugs	$75 copay or 30% coinsurance (Greater Amount)/ prescription (retail order)	Non-Preferred Provider: $90 copay or 30% /31-day supply	Covers up to a 34-day supply or 90-day (retail prescription); Therapy Class Restrictions Apply. **Disease Management** members pay the

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)	
		$225 copay or 30% coinsurance (Greater Amount)/ prescription (retail 90 network)		same amount. **Diabetes Management** members pay $5 for 34-day supply, at approved Pharmacy stores.
	Specialty drugs	$250 copay or 20% coinsurance (Lesser Amount)/ prescription	Not Covered	Covers up to a 34-day supply (mail order and retail specialty prescription) Prior Authorization may be required. **Disease Management** members pay the same amount **Diabetes Management** members pay $100 for 34-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Prior Authorization is required
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Prior Authorization is required
If you need immediate medical attention	Emergency room care	$200/day copay	$200/day copay	None
	Emergency medical transportation	20% coinsurance	50% coinsurance	None
	Urgent care	$50 copay/visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior Authorization is required
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit and 20% coinsurance for other outpatient services	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Prior Authorization is required
If you are pregnant	Office visits	$50 copay/visit	50% coinsurance	Cost sharing does not apply to certain preventive services.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Prior Authorization is required for longer than expected stays
If you need help	Home health care	20% coinsurance	50% coinsurance	1 visit/day and 120 days/year. Prior

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)	
recovering or have other special health needs				Authorization is required
	Rehabilitation services	20% coinsurance	50% coinsurance	Prior Authorization is required
	Habilitation services	20% coinsurance	50% coinsurance	Prior Authorization is required
	Skilled nursing care	20% coinsurance	50% coinsurance	120 days/year. Prior Authorization is required
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior Authorization may be required
	Hospice services	No Charge (Includes Home Care by Hospice)	50% coinsurance	30 day/benefit period. Prior Authorization is required
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Home Health Aide, when not provided by Hospice
- Infertility Treatment
- Long-term Care
- Non-emergency Care when traveling outside the U.S.
- Private-duty Nursing
- Routine Eye Care
- 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.)

- Acupuncture
- Atlas Orthogonal Care
- 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 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 TLC Benefit Solutions, Inc. at 1-877-949-0940. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (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 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:
Para obtener asistencia en Español, llame al 1-877-949-0940.

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	$800
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$12800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$800
Copayments	$960
Coinsurance	$2001
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,821**

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

The plan's overall deductible	$800
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$7500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$1740
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2968**

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

The plan's overall deductible	$800
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$1900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$350
Coinsurance	$283
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$1433**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: TLC Benefit Solutions, Inc. at 1-877-949-0940.

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