




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, [www.myLuminareHealth.com](http://www.myLuminareHealth.com). 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 1-877-498-8937 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$2,500 / individual or \$5,000 / family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Prescription drugs, <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,500 individual / \$7,000 family per calendar year – medical and <a href="#">prescription drug</a> combined \$1,350 individual / \$2,700 family per calendar year - <a href="#">prescription drug</a> only	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family <a href="#">out-of-pocket</a> limit must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myLuminareHealth.com">www.myLuminareHealth.com</a> or call 1-877-498-8937 for a list of <a href="#">preferred providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">non-preferred provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">preferred provider</a> might use a <a href="#">non-preferred provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Some services require prior authorization.
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Some services require prior authorization.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Some services require prior authorization.
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Prior authorization required.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at - <a href="http://www.optumrx.com">www.optumrx.com</a> or call 1 800-788-4863. This <a href="#">plan</a> follows the OptumRx Premium Formulary.	Generic drugs	10% <a href="#">coinsurance</a>	Not Covered	<a href="#">Copay</a> applies to a 30-day supply Retail and Specialty drugs or 31-90 day supply Mail-Order prescription. <a href="#">Copay</a> does not apply to preventive drugs required by the Affordable Care Act. If you purchase a brand name drug when a generic drug is available, you must pay difference in cost. <a href="#">Specialty drugs</a> must be filled at Optum Specialty. For more information, visit <a href="http://specialty.optumrx.com/">http://specialty.optumrx.com/</a> or call Optum Specialty at 1-844-265-1761.
	Preferred brand drugs	10% <a href="#">coinsurance</a>	Not Covered	
	Non-preferred brand drugs	10% <a href="#">coinsurance</a>	Not Covered	
	<a href="#">Specialty drugs</a>	10% <a href="#">coinsurance</a>	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Prior authorization required for certain surgeries.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Prior authorization required for certain surgeries.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	Preferred <a href="#">provider</a> benefit applies.	Non-emergency use of the emergency room is not covered.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	Preferred <a href="#">provider</a> benefit applies.	Must meet emergency criteria.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	Preferred <a href="#">provider</a> benefit applies.	Applies to <a href="#">urgent care</a> facilities.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Prior authorization required.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Some services require prior authorization.
	Inpatient services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Prior authorization required. Includes facility and physician fees.
If you are pregnant	Office visits	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> .
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Depending on the type of services, a <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Special Delivery program available through Optum Health.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Prior authorization required.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	Not Covered	Prior authorization required after 5 visits. 30 combined visits for physical, speech and occupational therapy in a calendar year.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	Not Covered	None.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	Not Covered	Prior authorization required.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Prior authorization required for certain equipment.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None.
If your child needs dental or eye care	Children's eye exam	\$20 <a href="#">copay</a> ( <a href="#">deductible</a> does not apply)	Payment up to the allowed amount less the \$20 <a href="#">copay</a> ( <a href="#">deductible</a> does not apply)	One routine exam per calendar 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](#).)

- |   |  |  |
|---|--|--|
| • Acupuncture   | • Hearing aids                                       | • Routine foot care (except for treatment of diabetes) |
| • Cosmetic surgery (except with prior authorization for reconstruction) | • Long-term care                                     | • Weight loss programs                                 |
| • Dental care (adult/child)   | • Non-emergency care when traveling outside the U.S. |  |

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

- |                     |                           |                                  |
|---------------------|---------------------------|----------------------------------|
| • Bariatric surgery | • Infertility medications | • Private-duty nursing           |
| • Chiropractic care | • Habilitation services   | • Routine eye care (adult/child) |

**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](http://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](http://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](http://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 1-877-498-8937.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-498-8937.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-498-8937.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-877-498-8937 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-498-8937.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-877-498-8937.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-877-498-8937.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-877-498-8937.

**To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.**

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

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,560</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,820</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500
■ <a href="#">Specialist coinsurance</a>	10%
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,530</b>

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