Subject to plan allowable **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, go to www.detegohealth.com or call 1-866-815-6001 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. dol.gov/ebsa/healthreform.com or www.cciio.cms.gov.

The Annual Maximum for this policy is limited to $40,000.00 per Benefit Period.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	None	There is no deductible for this plan.
Are there services covered before you meet your deductible?	Yes	There is no deductible for this plan.
Are there other deductibles for specific services?	None	There is no deductible for this plan.
What is the out-of-pocket limit for this plan?	None	There is no out-of-pocket for this plan.
What is not included in the out-of-pocket limit?	Not applicable	There is no out-of-pocket for this plan.
Will you pay less if you use a network provider?	No network restrictions.	There are no network restrictions for this plan.
Do you need a referral to see a specialist?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness 6 for Employee Tier 12 for Family Tier	$20 copay/visit	Subject to plan allowable
	Specialist visit 6 for Employee Tier 12 for Family Tier	$40 copay/visit	Subject to plan allowable
	Preventive care/screening/ immunization	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Services are limited to those covered by the Affordable Care Act. Annual physical not available until 9 months after effective date. All services must be conducted in office, hospital services are not covered.
	Tele-Medicine	$5 copay/visit	Unlimited
If you have a test	Diagnostic test (X-ray and blood work) 6 for Employee Tier 12 for Family Tier	$60 copay per visit	Subject to plan allowable
	Imaging (CT/PET scans, MRIs) 2 per Benefit Period If Green Imaging is used Up to 5 Per Benefit Period	$150 copay per visit	Subject to plan allowable
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at myfreepharmacy.com	Generic drugs	$0 Copay	All drugs are through our Precision RX Program Formulary Only
	Specialty drugs	Precision Rx	None (Patient Assistance Program Only)

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

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery. Claims Control Pro will assist you with balance bills. Email memberservices@detegohealth.com https://www.claimcontrolpro.com/	Ambulatory Surgical Center 1 Per Employee/ Per Benefit Period 2 Per Family/ Per Benefit Period	$500 Copay/Per surgery	Subject to plan allowable. Capped at $2,500 per Surgery
	Outpatient Hospital Surgery 1 Per Employee/ Per Benefit Period 2 Per Family/ Per Benefit Period	$500 copay/surgery	Subject to plan allowable. Capped at $2,500 per Surgery
	Outpatient Hospital Facility Charge 1 Per Employee/ Per Benefit Period 2 Per Family/ Per Benefit Period	$500 Copay/Per surgery	Subject to plan allowable. Capped at $2,500 per Surgery
	Physician/surgeon fees 1 Per Employee/ Per Benefit Period 2 Per Family/ Per Benefit Period	$500 copay/visit	Subject to plan. Capped at $2,500 per Surgery
If you need immediate medical attention	Emergency room care 2 Per Benefit Period	$350 copay/visit	Subject to plan allowable. Copayment waived if admitted.
	Emergency medical transportation 2 Per Benefit Period	$500 copay/transport	Capped at $1000 Subject to plan allowable
	Urgent care 3 Per Employee/ Per Benefit Period 6 Per Family/ Per Benefit Period	$60 copay/visit	Subject to plan allowable
If you have outpatient surgery. Claims Control Pro will assist you with balance bills. Email memberservices@detegohealth.com	Facility fee (e.g., hospital room) 6 days per benefit period	$150 copay/day limited to $750 per day	Subject to plan allowable
	Inpatient Surgery 1 Per Employee Per Benefit Period 2 Per Family Per Benefit Period	$500 copay/stay	Capped at $6,500 per surgery. Subject to plan allowable.
	Physician/surgeon fees 1 Per Employee Per Benefit Period 2 Per Family Per Benefit Period	$500 copay/visit	Capped at $2,500 per Surgery. Subject to plan allowable

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

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
	Inpatient rehabilitation	No Coverage	None
If you need mental health, behavioral health and substance abuse services	Outpatient services	No Coverage	None
	Inpatient services 4 days per benefit period	$60 copay/day	Subject to plan allowable
If you have outpatient surgery. **Claims Control Pro will assist you with balance bills.** **Email memberservices@detegohealth.com**	Office visits	No Charge	Subject to plan allowable
	Childbirth/delivery professional services	$500 copay/visit	Subject to plan allowable
	Childbirth/delivery facility services 5 days per benefit period	$150 copay/day, limited to $750 per day.	Subject to plan allowable
If you need help recovering or have other special health needs	Home health care	No Coverage	None
	Chiropractic services 12 per benefit period	$60 copay/visit	Subject to plan allowable
	Habilitation services	No Coverage	None
	Skilled nursing care	No Coverage	None
	Durable medical equipment	25% Coinsurance	Capped at $1000 Per Benefit Period, subject to plan allowable
	Hospice services	No Coverage	None
If your child needs dental or eye care	Children's eye exam	No charge	1 exam/member/benefit period.
	Children's glasses	No charge	40% off.
	Children's dental check-up	No charge	Subject to Plan Allowable

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

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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Durable Medical Equipment
- Infertility treatments
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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
- Diagnostic Testing
- Emergency Room Visits
- Inpatient/Outpatient Surgery
- PCP/Specialist Office Visits
- Prescriptions
- Urgent Care Visits

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: Detego health at 866-815-6001 or 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**
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. **The Annual Maximum for this policy is limited to $40,000.00 per Benefit Period.**

Does this plan meet the Minimum Value Standards? **No**
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 [877-585-8480]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [877-585-8480]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[877-585-8480]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [877-585-8480]

[* For more information about limitations and exceptions, see the plan or policy document at www.detegohealth.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 pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **$150**
- **Other *[cost sharing]*** **$500**

This EXAMPLE event includes services like:
Primary care 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	$0.00
Copayments	$750
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$750**

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

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$40**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **$60/20**

This EXAMPLE event includes services like:
Primary care office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*
Limited to $1000 Per Benefit Period

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$360
Coinsurance	$250
What isn't covered	
Limits or exclusions (Durable Medical Equipment)	$200
The total Joe would pay is	**$810**

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

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$40**
- **Hospital (facility) *[cost sharing]*** **$350**
- **Other *[cost sharing]*** **$60**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)* Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)* **25% Coinsurance up to $1000**
Rehabilitation services *(physical therapy)* **Not covered $400**

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$620
Coinsurance	$250
What isn't covered	
Limits or exclusions	$350
The total Mia would pay is	**$1,220**

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