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.shpg.com or call 800-648-7563. For general definitions of common terms, such as allowed amount, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 800-648-7563 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Navicent Health Preferred and Secure Health Network providers combined, **$1,400** Individual / **$2,800** Family. For Out-of-Network providers, **$3,200** Individual/ **$6,400** Family.	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 office visit 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, **$3,600** Individual / **$7,200** Family. For non-Network providers, **$7,200** Individuals / **$14,400** Family.	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?	Precertification program penalties, premiums, 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.shpg.com or call 478-314-2400 or 800-648-7563 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 pay the least if you use a provider in the Navicent Health Preferred Network. You will pay more if you use a provider in the Secure Health Network. You will pay the most if you use an out-of-network provider.
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
		PPO Provider (You will pay the least)		Non-PPO Provider	
		Atrium Navicent Preferred	Secure Health	(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	20% coinsurance	40% coinsurance	70% coinsurance	MRI's, MRA's, CT scans, PET scans, Radiation and Infusion therapy services must be performed by a Navicent Health Preferred facility or not covered.
	Specialist visit	20% coinsurance	40% coinsurance	70% coinsurance	
	Preventive care/screening/ immunization	No Charge	No Charge	70% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventative. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Not Covered	Limited to outpatient x-ray and lab.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	Not Covered	Must be performed at a Navicent Health Preferred facility.
If you need drugs to treat your illness or condition For more information about **prescription drug coverage** contact Optum Rx at 888-727-5560.	***Deductible must be met then copay applies.**	**Retail (30-day Supply)**	**Mail Order (30-day Supply)**	**Mail Order (90-day Supply)**	Certain Specialty prescription drugs may be subject to a separate cost share that may vary due to the Variable Copay™ Program. ***Deductible applies to prescription benefits for Generics, Preferred Brands, Non-Preferred Brands, and Specialty drugs.** Deductible does not apply to ACA and Preventive drugs. Certain infusion, injectable and specialty drugs have specific requirements as to where they must be obtained in order to be covered under the plan. Contact Secure Health to ensure the maximum benefit available to you.
	ACA (only 1 fill allowed for Retail)	$0.00	$0.00	$0.00	
	Preventive (only 1 fill allowed for Retail)	$20.00 copay	$6.00 copay	$15.00 copay	
	Generics	*$20.00 copay	*$10.00 copay	*$25.00 copay	
	Preferred Brand	*$45.00 copay	*$35.00 copay	*$87.50 copay	
	Non-Preferred Brand	*$60.00 copay	*$60.00 copay	*$180.00 copay	
	Specialty drugs	Not Covered	*$60.00 copay	Not Covered	
	*Deductible applies to prescription benefits for Generics, Preferred Brands, Non-Preferred Brands, and Specialty drugs. Coverage for certain Fertility Drugs will be subject to above copays when prescribed by an approved provider and also subject to a $10,000 lifetime maximum.				

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)		Non-PPO Provider (You will pay the most)	
		Atrium Navicent Preferred	Secure Health		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Hospital or Freestanding Center: 20% coinsurance	Hospital or freestanding Center: 40% coinsurance	Not Covered	After 48 hours observation, preauthorization is required, or benefits will be reduced.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	70% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance	Your cost for non-emergency use of a Network Emergency Room is 50% co-insurance; deductible applies
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	70% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	70% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	70% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance		70% coinsurance	None
	Inpatient services	20% coinsurance		70% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
If you are pregnant	Office visits	No Charge	No Charge	70% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	70% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	70% coinsurance	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)		Non-PPO Provider	
		Atrium Navicent Preferred	Secure Health	(You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	70% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	Rehabilitation services	20% coinsurance	40% coinsurance	70% coinsurance	Limited to 50 visits per calendar year for each therapy: Speech, Occupational, and Physical therapy.
	Habilitation services	Not Covered	Not Covered	Not Covered	None
	Skilled nursing care	20% coinsurance	40% coinsurance	70% coinsurance	Limited to 90 days per calendar year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Durable medical equipment	20% coinsurance	40% coinsurance	70% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Hospice services	20% coinsurance	40% coinsurance	70% coinsurance	
If your child needs dental or eye care	Children's eye exam	Not Covered			None
	Children's glasses	Not Covered			None
	Children's dental check-up	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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Program

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Private-Duty Nursing

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

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 www.dol.gov/ebsa/healthreform or 1-866-444-EBSA. 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. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

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 1-800-648-7563.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-648-7563.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-648-7563.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-648-7563.

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	**$1,400**
Specialist coinsurance	**20%**
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,660**

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

The plan's overall deductible	**$1,400**
PCP coinsurance	**20%**
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

The plan's overall deductible	**$1,400**
Specialist coinsurance	**20%**
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,610**

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