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, call **1-833-865-1187** or visit www.myVirtualCareAccess.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 1-833-865-1187 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 Providers (Teladoc Health Medical Group and Coordinated Preferred providers with Referral): **$0** / individual or **$0** / family per plan year. Tier 2 Providers (Non-Coordinated Preferred providers without Referral): **$2,000** / individual or **$4,000** / family per plan year. **Note:** Nonpreferred providers **are NOT covered.**	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. Prescription drugs and the following services by a Tier 2 Provider: Preventive care services with a copay 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.

Important Questions	Answers	Why This Matters:
What is the out-of-pocket limit for this plan?	Tier 1 Providers (Teladoc Health Medical Group and Coordinated Preferred providers with Referral): **$4,000** / individual or **$8,000** / family per plan year. Tier 2 Providers (Non-Coordinated Preferred providers without Referral): **$8,550**/ individual or **$17,100** / family per plan year. **Note:** Nonpreferred providers **are NOT covered.**	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?	Penalties for failure to obtain preauthorization for services, 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 (preferred) provider?	Yes. See www.myVirtualCareAccess.com or call 1-833-865-1187 for a list of network providers.	This plan uses a provider network. You pay less if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. 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
		Tier 1 Teladoc Health Medical Group and Coordinated Preferred Providers (with Referral)	Tier 2 Non-Coordinated Preferred Providers (without Referral)	NOTE: Nonpreferred Providers are NOT covered (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	$0 copay / visit	30% coinsurance	None.
	Specialist visit	$0 copay / visit – Teladoc providers $60 copay / visit - preferred providers	30% coinsurance	None.
	Preventive care / screening / immunization	No charge	0% coinsurance (deductible does not apply)	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)	$0 copay	30% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	$250 copay	30% coinsurance	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information NOTE: Nonpreferred Providers are NOT covered (You will pay the most)
		Tier 1 Teladoc Health Medical Group and Coordinated Preferred Providers (with Referral)	Tier 2 Non-Coordinated Preferred Providers (without Referral)	
	Preventive generic drugs	$0 copay (deductible does not apply)	$0 copay (deductible does not apply)	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call 1-844-328-9674	Generic drugs	Retail: $10 copay / prescription (deductible does not apply) Mail order: $15 copay / prescription (deductible does not apply)	Retail: $10 copay / prescription (deductible does not apply) Mail order: $15 copay / prescription (deductible does not apply)	Copay applies to a 30-day supply Retail and/or 31-90 day supply Mail-Order prescription. Copay does not apply to preventive drugs required by the Affordable Care Act. Nonpreferred provider pharmacy (retail and/or mail order) is NOT covered.
	Preferred brand drugs	Retail: $30 copay / prescription (deductible does not apply) Mail order: $45 copay / prescription (deductible does not apply)	Retail: $30 copay / prescription (deductible does not apply) Mail order: $45 copay / prescription (deductible does not apply)	
	Non-preferred brand drugs	Retail: $60 copay / prescription (deductible does not apply) Mail order: $90 copay / prescription (deductible does not apply)	Retail: $60 copay / prescription (deductible does not apply) Mail order: $90 copay / prescription (deductible does not apply)	
	Specialty drugs	30% coinsurance after Tier 2 deductible	30% coinsurance after Tier 2 deductible	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information NOTE: Nonpreferred Providers are NOT covered (You will pay the most)
		Tier 1 Teladoc Health Medical Group and Coordinated Preferred Providers (with Referral)	Tier 2 Non-Coordinated Preferred Providers (without Referral)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay	30% coinsurance	Preauthorization is required for some procedures.
	Physician/surgeon fees	Not applicable	30% coinsurance	None.
If you need immediate medical attention	Emergency room care	$100 copay / visit (deductible does not apply)		Copay waived if admitted.
	Emergency medical transportation	Land: $500 copay Air: 30% coinsurance		None.
	Urgent care	$0 copay / visit – Teladoc 24/7 on demand care $80 copay / visit - preferred providers	30% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 copay	30% coinsurance	Preauthorization is required.
	Physician/surgeon fees	Not applicable	30% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copay / visit	30% coinsurance	Preauthorization is required for partial hospitalization.
	Inpatient services	$1,000 copay	30% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	$0 copay / visit	0% coinsurance (deductible does not apply)	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	Not applicable	30% coinsurance	
	Childbirth/delivery facility services	$1,000 copay	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information NOTE: Nonpreferred Providers are NOT covered (You will pay the most)
		Tier 1 Teladoc Health Medical Group and Coordinated Preferred Providers (with Referral)	Tier 2 Non-Coordinated Preferred Providers (without Referral)	
If you need help recovering or have other special health needs	Home health care	$60 copay	30% coinsurance	Limited to 40 visits combined for home health care and outpatient private duty nursing per benefit period. Preauthorization is required.
	Rehabilitation services	$60 copay	30% coinsurance	Preauthorization is required.
	Habilitation services	$60 copay	30% coinsurance	Preauthorization is required.
	Skilled nursing care	$1,000 copay	30% coinsurance	Limited to 60 days per benefit period. Preauthorization is required.
	Durable medical equipment	$60 copay	30% coinsurance	Preauthorization is required.
	Hospice services	Inpatient: $1,000 copay Outpatient: $60 copay	30% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for Children's eye exam.
	Children's glasses	Not covered	Not covered	No coverage for Children's glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for Children's dental check-up.

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
- Eye care (children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care, except as covered for diabetes

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (Limited to 25 visits per benefit period) • Bariatric surgery • Chiropractic care	• Hearing aids (Limited to $1,000 per benefit period) • Infertility treatment (Limited to $20,000 while covered by this plan)	• Private-duty nursing (Limited to 40 combined visits for home health care and outpatient private duty nursing per benefit period) • Routine eye care • Weight loss programs

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 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 1-833-865-1187.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-833-865-1187.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-865-1187.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf uff 1-833-865-1187.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-865-1187.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-865-1187.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-865-1187.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-865-1187.

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 network (preferred) provider pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$60**
- **Hospital (facility) copayment** **$1,000**
- **Other coinsurance** **N/A**

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	$0
Copayments	$2,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2.460**

Managing Joe's Type 2 Diabetes

(a year of routine network (preferred) provider care of a well- controlled

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$60**
- **Hospital (facility) copayment** **$1,000**
- **Other coinsurance** **N/A**

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	$0
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

Mia's Simple Fracture

(network (preferred) provider emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$60**
- **Hospital (facility) copayment** **$1,000**
- **Other coinsurance** **N/A**

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	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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