



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, visit www.mhchealthcare.AHRICbenefits.com or by calling 1-866-952-0357. 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.mhchealthcare.AHRICbenefits.com or call 1-866-952-0357 to request a copy.

Important Questions	Answers	Why this Matters:
<p>What is the overall deductible?</p>	<p>\$4,000 person / \$8,000 family In-network \$8,000 person / \$16,000 family Out-of-network \$4,000 In-network / \$8,000 Out-of-network Maximum amount that any one person will satisfy toward the annual family deductible</p>	<p>Generally, you must pay all 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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care services are covered before you meet your deductible.</p>	<p>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/</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>\$6,500 person / \$13,000 family In-network Unlimited Out-of-network \$6,500 In-network Maximum amount that any one person will satisfy toward the annual family out-of-pocket</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Penalties, premiums, balance billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.mhchealthcare.AHRICbenefits.com or call 1-866-952-0357 for a list of network providers.</p>	<p>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 (a 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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>



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
		In-network (You will pay the least)	Out-of-network (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	50% Coinsurance	None
	Specialist visit	20% Coinsurance	50% Coinsurance	None
	Preventive care/screening/immunization	No charge; Deductible Waived	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 office setting; Not covered outpatient setting or an outpatient hospital	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance office setting; Not covered outpatient setting or an outpatient hospital	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.caremark.com .	Generic drugs (Tier 1)	Retail: \$10 copay after deductible Mail-Order: \$25 copay after deductible	Retail: \$10 copay after deductible	Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply 90 day supply at CVS retail pharmacy subject to Mail-Order copay. Specialty drugs 31 day supply regardless of retail or mail order. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by CVS/Caremark. Certain drugs may have a prior authorization requirement. Not all drugs are covered. If you use a non-network pharmacy, you are responsible for any amount over the allowed amount. Prescription drug costs are subject to the annual deductible. Deductible does not apply to certain preventive medications. Certain preventive medications are covered at No Charge
	Preferred brand drugs (Tier 2)	Retail: \$30 copay after deductible Mail-Order: \$75 copay after deductible	Retail: \$30 copay after deductible	
	Non-preferred brand drugs (Tier 3)	Retail: \$50 copay after deductible Mail-Order: \$125 copay after deductible	Retail: \$50 copay after deductible	
	Specialty drugs (Tier 4)	Retail: \$50 copay after deductible Mail-Order: \$50 copay after deductible	Retail: \$50 copay after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not covered	None
	Physician/surgeon fees	20% Coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service for Non-emergency.
	Urgent care	20% Coinsurance	50% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	50% 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 fee	20% Coinsurance	50% Coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% Coinsurance	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service for Partial hospitalization.
	Inpatient services	20% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
If you are pregnant	Office visits	No charge; Deductible Waived	50% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	50% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	50% Coinsurance	60 Maximum visits per calendar year; 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	50% Coinsurance office therapy; Not covered hospital therapy or outpatient facility	20 Maximum visits per calendar year OT; 20 Maximum visits per calendar year PT; 20 Maximum visits per calendar year ST
	Habilitation services	20% Coinsurance	50% Coinsurance office therapy; Not covered hospital therapy or outpatient facility	20 Maximum visits per calendar year
	Skilled nursing care	20% Coinsurance	50% Coinsurance	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	Durable medical equipment	20% Coinsurance	50% Coinsurance	Preauthorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases. If you don't get preauthorization, benefits could be reduced by 20% per occurrence.
	Hospice service	20% Coinsurance	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	20% Coinsurance	50% Coinsurance	1 Maximum exam every 2 years
	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](#) 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 (Adult)
- Infertility treatment
- 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.)

- Acupuncture
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Additionally, a consumer assistance program may help you file your [appeal](#). A list of states with Consumer Assistance Programs is available at [www.HealthCare.gov](http://cciio.cms.gov/programs/consumer/capgrants/index.html) and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

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 Standard? 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 1-866-952-0357.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-952-0357.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-952-0357.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-952-0357.]

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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	\$4,000
■ 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$4,000
Copayments	\$0
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Peg would pay is	\$5,600

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$4,000
■ Specialist 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,200
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$6,000
The total Joe would pay is	\$7,200

Mia's Simple Fracture

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

■ The plan's overall deductible	\$4,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,700
Copayments	\$0
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,740

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: www.mhhealthcare.AHRICbenefits.com or call 1-866-952-0357.

*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.