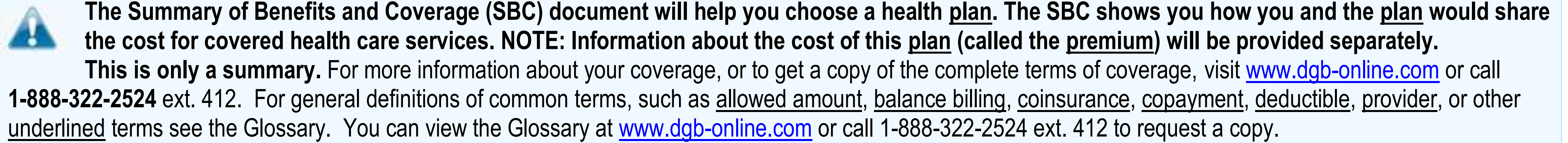
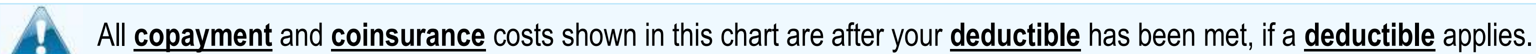


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.dgb-online.com or call **1-888-322-2524** ext. 412. 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.dgb-online.com or call 1-888-322-2524 ext. 412 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Hospital Facilities, Ambulatory Health Care Centers, PPO and Non-PPO Providers **$4,000** single/**$8,000*** family ***$4,000** embedded deductible Deductibles are per calendar year.	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 embedded 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 services and PPO Prenatal & Preconception care 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?	Hospital Facilities, Ambulatory Health Care Centers, PPO & Non-PPO Providers **$5,500** single/**$11,000*** family ***$5,500** embedded out-of-pocket limit Out-of-Pocket Limits are per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own embedded out-of-pocket limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, pre-authorization penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes, PHCS (for Physician and non-facility providers only). See www.multiplan.com/phcspracanc or call **1-877-952-7427** for a list of preferred providers.	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 (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.
Do you need a referral to see a specialist?	No.	You can see a 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
		Network Provider (You will pay the least)	Out-of-Network Provider (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*	20% coinsurance*	Hospital Facilities and Ambulatory Health Care Centers paid up to Allowable Claim Limits. Chiropractic care 40 visits per calendar year. Preauthorization is required for Office Surgery which exceeds $1,000 or you pay $500 more. Includes Teladoc medical services.
	Specialist visit			
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; 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. Hospital Facilities and Ambulatory Health Care Centers paid up to Allowable Claim Limits.

***After Deductible**

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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance*	20% coinsurance*	Hospital Facilities and Ambulatory Health Care Centers paid up to Allowable Claim Limits.
	Imaging (CT/PET scans, MRIs)	20% coinsurance*	20% coinsurance*	Hospital Facilities and Ambulatory Health Care Centers paid up to Allowable Claim Limits. Preauthorization is required or you pay $500 more.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empirxhealth.com	Generic drugs	20% coinsurance*	20% coinsurance*	Preventive (safe harbor) drugs: No charge; deductible does not apply. Covers 90-day supply retail.
	Preferred brand drugs	20% coinsurance*	20% coinsurance*	
	Non-preferred brand drugs	20% coinsurance*	20% coinsurance*	
	Specialty/Biotech drugs	20% coinsurance*	20% coinsurance*	Preauthorization is required. If you don't get preauthorization, there will be no coverage. Covers up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance* up to allowable claim limit under the Claim Review & Audit Program.		Preauthorization is required or you pay $500 more.
	Physician/surgeon fees	20% coinsurance*	20% coinsurance*	
If you need immediate medical attention	Emergency room care	20% coinsurance* up to allowable claim limit under the Claim Review & Audit Program.		None
	Emergency medical transportation	20% coinsurance*	20% coinsurance*	Professional local ambulance to and from nearest hospital. Hospital Facilities and Ambulatory Health Care Centers paid up to Allowable Claim Limits.
	Urgent care	20% coinsurance*	20% coinsurance*	None

***After Deductible**

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance* up to allowable claim limit under the Claim Review & Audit Program.		Preauthorization is required or you pay $500 more.
	Physician/surgeon fees	20% coinsurance*	20% coinsurance*	
If you need mental health, behavioral health, or substance abuse services	Physician services	20% coinsurance*	20% coinsurance*	Hospital Facilities and Ambulatory Health Care Centers paid up to Allowable Claim Limits.
	Inpatient/Partial Hospitalization services	20% coinsurance* up to allowable claim limit under the Claim Review & Audit Program.		Preauthorization is required for Inpatient confinements or you pay $500 more.
If you are pregnant	Office visits	Prenatal/Preconception: No charge; deductible does not apply Postnatal: 20% coinsurance*	20% coinsurance*	Hospital Facilities and Ambulatory Health Care Centers paid up to Allowable Claim Limits.
	Childbirth/delivery professional services	20% coinsurance*	20% coinsurance*	Preauthorization is required if stay exceeds 48 hours normal delivery/96 hours cesarean or you pay $500 more.
	Childbirth/delivery facility services	20% coinsurance* up to allowable claim limit under the Claim Review & Audit Program.		

***After Deductible**

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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance*	20% coinsurance*	100 visits per calendar year. Preauthorization is required or you pay $500 more.
	Rehabilitation services	20% coinsurance*	20% coinsurance*	Physical, Speech, Occupational, Respiratory and Cognitive Therapy 60 visits combined per calendar year. Cardiac rehabilitation 36 visits per calendar year. Hospital Facilities and Ambulatory Health Care Centers paid up to Allowable Claim Limits. Developmental delay, education & training excluded.
	Habilitation services	20% coinsurance*	20% coinsurance*	
	Skilled nursing care	20% coinsurance* up to allowable claim limit under the Claim Review & Audit Program.		Skilled Nursing/Extended Care facility 180 days per calendar year. Preauthorization is required or you pay $500 more.
	Durable medical equipment	20% coinsurance*	20% coinsurance*	Preauthorization is required for specialized DME which exceeds $1,500 or you pay $500 more.
	Hospice services	20% coinsurance*	20% coinsurance*	None
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	No charge; deductible does not apply	1 exam per calendar year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

***After Deductible**

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 • Cosmetic Surgery • Dental Care	• Infertility Treatment • Long-Term Care • 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.)		
• Bariatric Surgery • Chiropractic Care (40 visits per calendar year)	• Hearing Aids (2 devices per calendar year up to $6,000)	• Most non-elective services provided outside the United States • Routine Eye Care

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: 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 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.

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** **$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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,460**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,200**

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 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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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