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.scptac.org . 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.scptac.org or call 1 (800) 595-7473 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$250** individual / **$750** family	You must pay all Allowable Charges up to the deductible amount before this plan begins to pay for covered services you use. Your deductible starts over January 1st. The amounts you pay over the Allowable Charge, or allowed amount, do not count toward the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. The other deductibles for specific services do not apply to the overall deductible.
Are there services covered before you meet your deductible?	Yes, vision.	Vision services do not require you to meet a deductible before coverage begins.
Are there other deductibles for specific services?	Yes. **$50** for prescription drugs; **$50** per device for hearing aid, and; **$50** for PPO dental election, up to **$150** family. There are no other specific deductibles.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The overall deductible does not apply to prescription, hearing aid, and PPO dental services..
What is the out-of-pocket limit for this plan?	Yes: In-network: $9,100 individual, and $18,200 family. Out-of-network: $18,200 individual and $36,400 family.	This is the most you **could** pay in deductibles and coinsurance during a calendar year for your share of the costs of covered services. The overall, prescription drug, and hearing aid deductibles apply to the out-of-pocket limit. After you meet this limit the Plan will pay 100% of the allowed amount, also referred to as the Allowable Charge. This limit never includes your premium, balanced-billed charges, or out of network payments that are over the allowed amount.
What is not included in the out-of-pocket limit?	Non-covered services and amounts over the allowance are not included in the out-of-pocket limit.	If you use an out-of-network provider only the allowed amount, referred to as the Allowable Charge in your Summary Plan Description, applies to the yearly out-of-pocket limit. Non-covered services and costs over the allowed amount do not apply to the out-of-pocket limit. Some benefits have dollar or visit limitations, amounts over those limits do not apply to the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Note that your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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	0% coinsurance	Disallowed amount	---none---
	Specialist visit	0% coinsurance	Disallowed amount	---none---
	Preventive care/screening/ Immunization	0% coinsurance	Disallowed amount	---none---
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Disallowed amount	---none---
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Disallowed amount	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.scptac.org	Generic drugs	• 0% coinsurance for the first $1,800 • 50% coinsurance $1,801 - $6,000 • 35% coinsurance above $6,000	• 0% coinsurance for the first $1,800 • 50% coinsurance $1,801 - $6,000 • 35% coinsurance above $6,000	Coinsurance after the first $50 for all prescription drugs in a calendar year
	Preferred brand drugs	• 0% coinsurance for the first $1,800 • 50% coinsurance $1,801 - $6,000 • 35% coinsurance above $6,000	• 0% coinsurance for the first $1,800 • 50% coinsurance $1,801 - $6,000 • 35% coinsurance above $6,000	Coinsurance after the first $50 for all prescription drugs in a calendar year
	Non-preferred brand drugs	• 0% coinsurance for the first $1,800 • 50% coinsurance $1,801 - $6,000 • 35% coinsurance above $6,000	• 0% coinsurance for the first $1,800 • 50% coinsurance $1,801 - $6,000 • 35% coinsurance above $6,000	Coinsurance after the first $50 for all prescription drugs in a calendar year
	Specialty drugs	5% coinsurance	5% coinsurance + disallowed amount	Some specialty drugs may be subject to the coinsurance indicated for non specialty drugs

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

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	10% coinsurance + disallowed amount	The Plan will pay up to $1,215 per day for non-emergency outpatient services in an out-of-network provider (hospital)
	Physician/surgeon fees			---none---
If you need immediate medical attention	Emergency room care Facility fee	0% coinsurance 5% coinsurance	Disallowed amount	---none---
	Emergency medical transportation	20% coinsurance	20% coinsurance + disallowed amount	---none---
	Urgent care	0% coinsurance	Disallowed amount	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	10% coinsurance + disallowed amount	The Plan will pay up to $1,215 per day for non-emergency outpatient services in an out-of-network provider (hospital). Separate limits apply to transplant services.
	Physician/surgeon fees	0% coinsurance	Disallowed amount	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	Disallowed amount	Treatment of substance abuse and/or alcoholism is not covered by the Plan
	Inpatient services	0% coinsurance	Disallowed amount	Treatment of substance abuse and/or alcoholism is not covered by the Plan
If you are pregnant	Office visits	0% coinsurance	Disallowed amount	Pregnancy for dependent children is not covered by the Plan
	Childbirth/delivery professional services	0% coinsurance	Disallowed amount	Pregnancy for dependent children is not covered by the Plan
	Childbirth/delivery facility services	5% coinsurance	10% coinsurance + disallowed amount	The Plan will allow $1,215 per day for non-emergency inpatient stay in an out-of-network provider (hospital) Pregnancy for dependent children is not covered by the Plan

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

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 need help recovering or have other special health needs	Home health care	5% coinsurance	5% coinsurance + disallowed amount	Home health care services are required to be provided by an R.N., L.V.N., L.P.N. or other care giver licensed to provide such services and is limited to 120 visits per calendar year
	Rehabilitation services	0% coinsurance	Disallowed amount	Speech therapy coverage is limited to $22.50/visit (out-of-network) Occupational therapy is covered for a hand injury or disability only
	Habilitation services	0% coinsurance	Disallowed amount	Speech therapy is not covered for developmental and/or learning disorders Occupational therapy is covered for a hand injury or disability only
	Skilled nursing care	5% coinsurance	10% coinsurance + disallowed amount	Skilled nursing facility care is limited to $27.00/day (out-of-network)
	Durable medical equipment	5% coinsurance	5% coinsurance + disallowed amount	Replacement allowed every three (3) years depending on device
	Hospice services	5% coinsurance	5% coinsurance + disallowed amount	---none---
If your child needs dental or eye care	Children's eye exam	$20 copayment for exam every 12 months	Disallowed amount	---none---
	Children's glasses	$20 (combined with exam) copayment and 0% coinsurance on glasses lenses or up to $130 on contacts every 12 months. $150 every 12 months for frames	Disallowed amount on lenses or amount over $130 on contacts every 12 months $150 every 12 months for frames	---none---
	Children's dental check-up	0% coinsurance	Amount that exceeds allowance	Coinsurance after the first $50 A dental election must be made to obtain any dental coverage.

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

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, except as specified	• Infertility treatment	• Long-term care
• Non-emergency care when traveling outside the U.S.	• Private-duty nursing	• Routine foot care
• Substance use disorder inpatient services	• Substance use disorder outpatient services	• The prescription drug, hearing aid, and PPO dental deductibles do not count toward satisfaction of the calendar year deductible
• Weight loss program		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture must be performed by a M.D. or L.Ac., up to 20 visits per calendar year	• Bariatric Surgery	• Chiropractic care up to 3 times per week and 35 visits per calendar year
• Dental Care (Adult)	• If you have contributions available in the Plan's Health Reimbursement Arrangement ("HRA"), you may access the HRA to pay or reimburse yourself for certain qualified medical expenses or to cover deductibles or copays, up to the balance available in your HRA	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: 1 (800) 474-3485. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (888) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x 61565 or www.cciio.cms.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: The Plan Administrative office at 1 (800) 595-7473 or the 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.

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) 595-7473

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

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

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	**$250**
Specialist *[cost sharing]*	**0%**
Hospital (facility) *[cost sharing]*	**5%**
Other *[cost sharing]*	**0%**

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	$300
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$760**

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

The plan's overall deductible	**$250**
Specialist *[cost sharing]*	**0%**
Hospital (facility) *[cost sharing]*	**5%**
Other *[cost sharing]*	**5%**

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	$300
Copayments	$0
Coinsurance	$1053
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1408**

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

The plan's overall deductible	**$250**
Specialist *[cost sharing]*	**0%**
Hospital (facility) *[cost sharing]*	**5%**
Other *[cost sharing]*	**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	$300
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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