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 1-877-624-6219 or visit www.mycreatehealth.com/employee. 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.healthcare.gov/sbc-glossary/ or call 1-877-624-6219 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 individual (single coverage) / $4,000 family per plan 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	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 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?	In-network: $3,000 individual (single coverage) / $5,000 family* Out-of-network: $4,000 individual (single coverage) / $8,000 family per plan year. *An individual on family coverage will not have their in-network out-of-pocket limit exceed $3,000.	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?	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 provider?	Yes. See www.mycreatehealth.com/employee or call 1-877-624-6219 or 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 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 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
		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	30% coinsurance	Coverage includes primary care visits at a retail clinic.
	Specialist visit	0% coinsurance	30% coinsurance	
	Preventive care/screening/ immunization	No charge	30% coinsurance, deductible does not apply	Coinsurance and deductible do not apply for childhood immunizations from out-of-network providers. 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% coinsurance	30% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-800-228-3108 or www.savrx.com.	Generic drugs	$5 copay / retail prescription $10 copay / mail order prescription		Your prescription drug coverage is administered through Sav-Rx. MagnaCare assumes no liability for the accuracy of your prescription drug benefits information. Prescription Drugs are subject to medical plan deductible.
	Preferred brand drugs	$25 copay / retail prescription $50 copay / mail order prescription		
	Non-preferred brand drugs	$50 copay / retail prescription $100 copay / mail order prescription		
	Specialty drugs	Refer to generic, preferred brand and brand drugs above. The first fill is allowed at a Pharmacy. Additional fills must be provided by the Sav-Rx Specialty Pharmacy.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	None.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None.
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	None.
	Emergency medical transportation	0% coinsurance	0% coinsurance	None.

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)	
	Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.		None.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	None.
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	0% coinsurance	None.
	Inpatient services	0% coinsurance	0% coinsurance	None.
If you are pregnant	Office visits	0% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	200 visits / year
	Rehabilitation services	0% coinsurance	30% coinsurance	30 inpatient days / year 90 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	0% coinsurance	30% coinsurance	50 outpatient neurodevelopmental visits / year Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	0% coinsurance	30% coinsurance	120 inpatient days / year
	Durable medical equipment	0% coinsurance	30% coinsurance	None
	Hospice services	0% coinsurance	30% coinsurance	30 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, except for diabetic patients
- Weight loss programs

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

- Abortion
- Acupuncture
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

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 1-866-444-3272 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: MagnaCare at 1-877-624-6219. You may also contact 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 1-877-624-6219.

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	$2,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	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	$2,000
Copayments	$9
Coinsurance	$0
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,070**

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

The plan's overall deductible	$2,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$1,919
Copayments	$436
Coinsurance	$0
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$2,533**

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

The plan's overall deductible	$2,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,000
Copayments	$5
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,005**

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