**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, go to www.abbotthealthplan.com or call 1-888-614-1011. 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.dol.gov/ebsa/healthreform or call 1-888-614-1011 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For in-network providers: **$100** per person/**$200** per family<br>For out-of-network providers: **$500** per person/**$1,250** per family | Generally, you must pay all of the costs from providers up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there services covered before you meet your deductible?** | Yes | 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/preventivecarebenefits/. See the chart starting on page 2 for a list of other services this plan covers. |
| **Are there other deductibles for specific services?** | Yes. **$100** per person/**$200** per family for prescription drugs. There are no other specific **deductibles**. | You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | For in-network providers: **$3,500** per person/**$8,000** per family. For out-of-network providers: **$7,000** per person/**$16,000** per family. For prescription drugs: **$1,500** per person/**$3,000** per family | 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?** | Contributions, balance-billed charges, 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**. |

| | | |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See **www.abbotthealthplan.com** or call **1-888-614-1011** for a list of participating providers. | 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. Be aware, 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 don't need a referral to see a specialist. | 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 | $25 copay/visit | 40% coinsurance | Copay applies to the office visit only. |
| | Specialist visit | $50 copay/visit | 40% coinsurance | Copay applies to the office visit only. |
| | Preventive care/screening/ immunization | No charge | 40% coinsurance | Annual preventive vision exam covered at no charge for a network provider, 40% coinsurance for an out-of-network provider. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | ——————none—————— |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.expressscripts.com | Generic drugs | 25% coinsurance retail/20% mail order | 25% coinsurance retail/20% mail order | After you meet your prescription deductible you pay:<br><br>Retail: 25% coinsurance (30 day supply)<br>Mail: 20% coinsurance (90 day supply)<br>Retail: Days Supply (1-30)<br>Generic: Min $5<br>Brand: Min $15<br>Retail: Days Supply (84-90)<br>Generic: Min $15<br>Brand: Min $35<br>Mail:<br>Generic: Min $15<br>Brand: Min $35 |
| | Preferred brand drugs | | | |
| | Non-preferred brand drugs | | | |
| | Specialty drugs | | | |

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

| 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) | 20% coinsurance | 40% coinsurance | Pre-certification is required |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | ————————none———————— |
| **If you need immediate medical attention** | Emergency room care | $250/visit, 20% coinsurance | $250/visit, 20% coinsurance | Copay waived if admitted to the hospital |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | ————————none———————— |
| | Urgent care | 20% coinsurance | 40% coinsurance | ————————none———————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | $250 penalty if not preauthorized |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | ————————none———————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/visit | 40% coinsurance | ————————none———————— |
| | Inpatient services | 20% coinsurance | 40% coinsurance | $250 penalty if not preauthorized. Includes intensive psychiatric day treatment and partial hospitalization. |
| **If you are pregnant** | Office visits | No charge for first visit, then 20% coinsurance | No charge for first visit, then 40% coinsurance | ————————none———————— |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | ————————none———————— |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | ————————none———————— |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Pre-certification is required |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | ————————none———————— |
| | Habilitation services | 20% coinsurance | 40% coinsurance | Medical necessity will be reviewed after 60 visits for occupational, physical and speech therapy (combined) |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | $250 penalty if not preauthorized |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Pre-certification is required for any rental or purchase over $500 |
| | Hospice services | No charge after deductible | 40% coinsurance | ————————none———————— |
| **If your child needs dental or eye care** | Children's eye exam | No charge. | 40% coinsurance | Limited to one per calendar year |
| | Children's glasses | Not covered | Not covered | |

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

| 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) | |
| | Children's dental check-up | Not covered | Not covered | |

**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 (adult)
- Long-term 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 up to 20 visits per person per calendar year
- Annual vision exam
- Bariatric surgery
- Chiropractic care up to 20 visits per person per calendar year
- Hearing aids
- Infertility treatment when approved and provided in-network
- Non-emergency care when traveling outside the U.S. covered at out-of-network benefit level
- Private-duty nursing
- Routine foot care (when medically necessary)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-888-614-1011. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 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: 1-888-614-1011. You can also contact the Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage?** **This plan or policy does provide minimum essential coverage.**
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?** **This health coverage does meet the minimum value standard for the benefits it provides.**
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.

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

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-614-1011.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-614-1011.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-888-614-1011.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-614-1011.

*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
(normal delivery)

| | |
|---|---|
| The plan's overall deductible | $100 |
| Specialist *[cost sharing]* | $50 |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $100 |
| Copayments | $0 |
| Coinsurance | $2,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,260** |

### Managing Joe's type 2 Diabetes
(routine maintenance of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $100 |
| Specialist *[cost sharing]* | $50 |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $200 |
| Copayments | $1,600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,860** |

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

| | |
|---|---|
| The plan's overall deductible | $100 |
| Specialist *[cost sharing]* | $50 |
| Hospital (facility) *[cost sharing]* | 20% |
| 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** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $100 |
| Copayments | $0 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$500** |

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

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