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.theamericanworker.com or call 1-855-495-1190. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-855-495-1190 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$6,500** per person / **$13,000** per family for Network Providers; **$13,000** per person / **$26,000** per family for Out-of-Network Providers.	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 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**	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?	**$6,500** per person / **$13,000** per family for Network Providers; **No Limit** per person / **No Limit** per family for Out-of-Network Providers.	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, amounts over UCR, cost containment 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.** Visit https://hstconnect.com or call 800-440-7427 for 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. This plan also uses Reference Based Pricing (RBP). Facility Plan payments are based on

Important Questions	Answers	Why This Matters:
		Reference Based Pricing (RBP) not to exceed 150% of Medicare Allowable for Facilities.
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	50% coinsurance	If you receive services in addition to an office visit, additional copays, deductibles or coinsurance may apply.
	Specialist visit	0% coinsurance	50% coinsurance	If you receive services in addition to an office visit, additional copays, deductibles or coinsurance may apply.
	Preventive care/screening/ immunization	No Charge	50% coinsurance	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. Certain age restrictions may apply.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	Plan payments are based on Reference Based Pricing (RBP).
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 844-636-7506 or visiting www.CerpassRx.com	Generic drugs	0% coinsurance	Not Covered	Medical Deductible applies Retail: up to a 30-day supply; Mail Order: up to a 90-day supply. • Certain drugs may have a pre-authorization requirement. • Preventive medications are covered at No Charge. • Not all drugs are covered.
	Preferred brand drugs	0% coinsurance	Not Covered	
	Non-preferred brand drugs	0% coinsurance	Not Covered	
	Specialty drugs	Not Covered	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at www.theamericanworker.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)	0% coinsurance		Plan payments are based on Reference Based Pricing (RBP). Preauthorization is required in order to avoid a benefit reduction of 20%.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance after in network deductible	Stand alone Emergency Rooms are covered under the PPO network. Hospital Emergency Rooms are covered under Reference Based Pricing (RBP).
	Emergency medical transportation	0% coinsurance	0% coinsurance after in network deductible	Preauthorization is required for facility to facility transports in order to avoid a benefit reduction of 20%. Only ground ambulance is covered.
	Urgent care	0% coinsurance	50% coinsurance	If you receive treatment in addition to urgent care, additional deductibles, copays or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance		Preauthorization is required in order to avoid a 20% benefit reduction.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	50% coinsurance	---None---
	Inpatient services	0% coinsurance		Preauthorization is required in order to avoid a 20% benefit reduction.
If you are pregnant	Office visits	0% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Preauthorization is required for vaginal deliveries requiring more than a 48-hour stay and for cesarean section deliveries requiring more than a 96-hour stay, in order to avoid a benefit reduction of 20%.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance		

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	0% coinsurance	50% coinsurance	Limited to 30 visits per calendar year. Preauthorization is required in order to avoid a 20% benefit reduction.
	Rehabilitation services	0% coinsurance	50% coinsurance	Limited to a combined 20 visits per calendar year for Physical, Speech and Occupational therapy. Pulmonary, Cognitive and Cardiac therapy is limited to 5 visits each per calendar year.
	Habilitation services	0% coinsurance	50% coinsurance	Limited to a combined 20 visits per calendar year for Physical, Speech and Occupational therapy.
	Skilled nursing care	Not Covered	Not Covered	Excluded Service
	Durable medical equipment	0% coinsurance	50% coinsurance	---None---
	Hospice services	0% coinsurance	50% coinsurance	Limited to 6 months in a 3-year period. Plan payments are based on Reference Based Pricing (RBP).
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Excluded Service
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

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
- Eye care (Child)
- Infertility treatment
- Private-duty nursing/Skilled nursing services
- Bariatric surgery
- Dental care (Adult)
- Long-term care
- Routine foot care
- Dental care (Child)
- Hearing aids
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)
- Weight loss programs

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

- Chiropractic (limited to 24 visits per calendar year)

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

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 on how 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 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 1-855-495-1190.

Important Note – Value Driven Health Plan:

Providers are reimbursed pursuant to the terms of the Plan Document up to the Reasonable and Allowable Amount (subject to reference pricing). Physician (and ancillary if applicable) services may be subject to a PPO Network. The Plan will only consider an Assignment of Benefits (AOB) valid under the condition that the Provider accepts the payment received from the Plan as consideration in full for the services, supplies and/or treatment rendered, less any required deductibles/copays/coinsurance.

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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.theamericanworker.com.

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	**$6,500**
Specialist *[cost sharing]*	**0%**
Hospital (facility) *[cost sharing]*	**0%**
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	$6,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,560**

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

The plan's overall deductible	**$6,500**
Specialist *[cost sharing]*	**0%**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**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	$5,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,420**

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

The plan's overall deductible	**$6,500**
Specialist *[cost sharing]*	**0%**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**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	$2,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Mia would pay is	**$2,800**

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