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 1-800-634-0173 or visit us at www.jpfarley.com. 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.jpfarley.com or call 1-800-634-0173 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Deductible?	Network: **$3,500** /Individual or **$6,000**/Family per Calendar Year Out-of-Network: **$8,000**/Individual or **$14,000**/Family 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 policy, they have to meet their own individual Deductible until the overall family Deductible has been met. Network/Out-of-Network Deductibles and any other benefit maximums do not cross-satisfy one another.
Are there services covered before you meet your Deductible?	**Yes**: Network Preventive Care; Network Physician's office visits; and Network Second Surgical Opinions.	This plan covers some items and services even if you haven't yet met the annual Deductible amount. But a Co-Payment 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/.com
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?	Network: **$6,400**/Individual or **$9,000**/Family per Calendar Year Out-of-Network: **$13,500**/Individual or **$14,700**/Family 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 in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met. Network/Out-of-Network out-of-pocket limits and any other benefit maximums do not cross-satisfy one another.
What is not included in the out-of-pocket limit?	Ineligible charges, amounts over the usual, reasonable & customary, premiums, balanced-billed 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 the back of your ID card for more information.	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 (a balance bill). 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 **Co-Payment** 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	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	$50 Copay/visit; deductible does not apply	40% after deductible is met	——————none——————
	Specialist visit	$80 Copay/visit; deductible does not apply	40% after deductible is met	——————none——————
	Preventive care/screening/ Immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what the plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% after deducible is met	40% after deductible is met	——————none——————
	Imaging (CT/PET scans, MRIs)	20% after deducible is met	40% after deductible is met	Pre-certification is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.truerx.com	Generic Drugs	Tier 0: Preferred Network: $0 Copayment 1–90 day supply (Retail) Tier 1: Preferred Network: $0 Copayment 1–90 day supply (Retail & Mail) Chain Retail: $50 copayment/30 day supply, $150 copayment/90 day supply (Mail)		Covers up to a 31-day Retail supply; Covers up to a 90-day Mail Order supply. No Co-Payment for generic prescriptions mandated by the Affordable Care Act (ACA), including, but not limited to, tobacco cessation medications and generic women's contraceptives. Chain Network: Walgreens, CVS, etc.
	Formulary Drugs	Preferred Network: $35 Copayment/30 day supply (Retail), $105 copayment/90 day supply (Mail) Chain Retail: $75 copayment/30 day supply, $225 copayment/90 day supply (Mail)		
	Non-Formulary Drugs	Preferred Network: $60 Copayment/30 day supply (Retail), $180 copayment/90 day supply (Mail) Chain Retail: $140 copayment/30 day supply, $420 copayment/90 day supply (Mail)		
	Specialty Drugs	Preferred Network: 75% cost of medication with a max of $300 Chain Retail: 50% of cost of medication, no max		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deducible is met	40% after deductible is met	——————none——————
	Services at PriceMD Surgical Centers	No Charge; Deductible waived	Not Covered	

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

	Physician/surgeon fees	20% after deducible is met	40% after deductible is met	——————none——————
If you need immediate medical attention	Emergency room care	$400 Copay; deductible does not apply		Non-Emergency use of ER is not covered.
	Emergency medical transportation	20% after deducible is met		——————none——————
	Urgent care	$75 Copay; deductible does not apply	40% after deductible is met	——————none——————

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deducible is met	40% after deductible is met	Pre-certification is required.
	Physician/surgeon fees	20% after deducible is met	40% after deductible is met	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services:	$50 Copay/visit; deductible does not apply	40% after deductible is met	——————none——————
	Inpatient services	20% after deducible is met	40% after deductible is met	Pre-certification is required.
If you are pregnant	Office visits	20% after deducible is met	40% after deductible is met	Depending on the type of services, a Coinsurance or Deductible may apply. Maternity care may include tests described elsewhere in the SBC (i.e. ultrasound). Pre-certification is required.
	Childbirth/delivery professional services	20% after deducible is met	40% after deductible is met	
	Childbirth/delivery facility services	20% after deducible is met	40% after deductible is met	
If you need help recovering or have other special health needs	Home health care	20% after deducible is met	40% after deductible is met	Limited to 60 visits per calendar year. Pre-certification is required.
	Rehabilitation and Habilitation services	20% after deducible is met	40% after deducible is met	Includes Physical Therapy, Occupational Therapy, Respiratory Therapy and Speech Therapy/Hearing 60 visits combined. Chiropractic visits: 20 visits per calendar year.
	Skilled nursing care	20% after deducible is met	40% after deducible is met	Limited to 60 days per calendar year combined with Inpatient Rehabilitation. Pre-certification is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% after deducible is met	40% after deducible is met	Pre-certification is required for equipment over $1,500 and if purchased, limited to a single purchase of a type of Durable Medical Equipment (Including repair/replacement) every three years.
	Hospice services	20% after deducible is met	40% after deducible is met	Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	Plan pays 100%	Not Covered	Child vision screening is included in the ACA's preventative services.
	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.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery	• Dental care (Adult) • Infertility treatment • Long-term Care	• Routine eye care (Adult) • Routine foot care • Weight loss programs • Non-emergency care when traveling outside the U.S.
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care	• Private-duty nursing (Medically Necessary) • Hearing Aids	

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. For more information on your rights to continue coverage, contact the claims administrator at 1-800-634-0173 or the plan at 1-336-724-5528.

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 claims administrator at 1-800-634-0173 or the plan at 1-336-724-5528.You can 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

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 800-634-0173. No spaces yet

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, Co-Payments 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 Network pre-natal care and a hospital delivery)

The plan's overall Deductible	**$3,500**
Specialist *[cost sharing]*	**20%**
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Co-Payments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,360**

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

The plan's overall Deductible	**$3,500**
Specialist *[cost sharing]*	**20%**
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Co-Payments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$5,060**

Mia's Simple Fracture
(Network emergency room visit and follow up care)

The plan's overall Deductible	**$3,500**
Specialist *[cost sharing]*	**20%**
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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Co-Payments	$0
Coinsurance	$450
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

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