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?	**$5,000** person / **$10,000** family for Network providers. **$10,000** person / **$20,000** family for Non-Network providers Does not apply to network preventive care, or primary care services. Cost containment penalties, copayments and amounts over the Maximum Allowable Charge do not count toward the **deductible.**	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. **Preventive care**, and other services as noted in this document are covered before you meet your **deductible.**	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply.
Are there other deductibles for specific services?	No. There are no other specific **deductibles**.	You do not have to meet **deductibles** for specific services, but see the chart titled Common Medical Event for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**$8,150** person / **$16,300** family for Network providers. **$16,300** person / **$32,600** family for Non- 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, prior authorization and cost containment penalties, **balance billed charges**, amounts over the **allowed amount** or Maximum Allowable Charge (see plan document) and health care this plan does not 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.jpfarley.com or call 1-800-634-0173 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.
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	Age 19 and over: $30 copay, deductible does not apply Under age 19: $0 copay, deductible does not apply	50% coinsurance after deductible	----------None----------
	Specialist visit	$60 copay, deductible does not apply	50% coinsurance after deductible	----------None----------
	Preventive care/screening/ immunization	$0 copay, deductible does not apply	30% coinsurance after deductible	Coverage includes preventive care and services required by applicable law. A current listing of required preventive care can be accessed at https://www.healthcare.gov/what-are-my-preventive-care-benefits
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance after deductible	Not Covered	----------None----------
	Imaging (CT/PET scans, MRIs)	$500 Copay per occurrence, then 50% after deducible is met	$500 Copay per occurrence, then 50% after deducible is met	Copayment will be waived by contacting Nurse Navigator and utilizing a contracted provider. Complex imaging (CT/PET scans) require precertification.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.jpfarley.com	Preventative (Tier 0) MakoRX 300+ Preventative RX	MakoRx Preferred Local $0 Copay/Chain Pharmacies $ 10 Copay (1 month Supply)/ $25 Copay (3 month supply); Deductible does not apply		Mako RX Preferred Local Pharmacy Network Chain Pharmacies: CVS, Walgreens, Etc.
	Generic drugs (Tier 1)	MakoRx Preferred Local $5 Copay (1 month supply)/ $12.50 Copay (3 month Supply)/Chain Pharmacies $ 10 Copay (1 month Supply)/ $25 Copay (3 month supply); Deductible does not apply		
	Preferred brand drugs (Tier 2)	MakoRx Preferred Local $25 Copay (1 month supply)/ $62.50 Copay (3 month Supply)/Chain Pharmacies $50 Copay (1 month Supply)/ $125 Copay (3 month supply); Deductible does not apply		
	Non-preferred brand drugs (Tier 3)	MakoRx Preferred Local $37.50 Copay (1 month supply)/ $93.75 Copay (3 month Supply)/Chain Pharmacies $75		

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)	
		Copay (1 month Supply)/ $187.50 Copay (3 month supply); Deductible does not apply		
	Specialty drugs (Tier 4)	MakoRx Preferred Local 25% coinsurance with a max of $50/ Chain Pharmacies 25% coinsurance with a max of $100; Deductible does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 Copay per occurrence, then 50% after deducible is met	50% coinsurance after deductible	Precertification is required. Copayment will be waived by contacting Nurse Navigator and utilizing a contracted provider.
	Physician/surgeon fees	50% coinsurance after deductible	50% coinsurance after deductible	Precertification is required.
If you need immediate medical attention	Emergency room care	50% coinsurance after deductible		----------None----------
	Emergency medical transportation	50% coinsurance after deductible		----------None----------
	Urgent care	$60 copay, deductible does not apply	50% coinsurance after deductible	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance after deductible	50% coinsurance after deductible	Limited to semi-private room rate. Precertification is required.
	Physician/surgeon fees	50% coinsurance after deductible	50% coinsurance after deductible	Precertification is required.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit- Age 19 and over: $30 copay, deductible does not apply Under age 19: $0 copay, deductible does not apply Other Outpatient Services- 50% coinsurance after deductible	50% coinsurance after deductible	Inpatient services require precertification.
	Inpatient services	50% coinsurance after deductible	50% coinsurance after deductible	
If you are pregnant	Office visits	50% coinsurance, after deductible	50% coinsurance after deductible	Service must be precertified for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
	Childbirth/delivery professional services	50% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	50% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	50% coinsurance after deductible	50% coinsurance after deductible	Precertification is required. 60 visits/ benefit period
	Rehabilitation services & Habilitation services	$30 copay, deductible does not apply	50% coinsurance after deductible	Precertification is required. Physical Therapy= 23 visits *Physical Therapy Copay will be waived if nurse is called and a direct contract is utilized Occupational Therapy- 23 visits Speech Therapy- 30 visits Post-cochlear implant aural therapy- 30 visits Cognitive Rehabilitation Therapy-20 visits Chiropractic/manipulative-20 visits **The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject

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)	
				to the annual visit limits
	Skilled nursing care	50% coinsurance after deductible	50% coinsurance after deductible	Precertification is required. Limited to 60 visits per benefit period. *combined with Inpatient Rehabilitation
	Durable medical equipment	50% coinsurance after deductible	Not Covered	Limited to a single purchase of a type of DME. Repair and/or replacement of DME, would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.
	Hospice services	50% coinsurance after deductible	50% coinsurance after deductible	Precertification is required
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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Dental Check up
- Infertility Treatment
- Private Duty Nursing
- Long Term Care
- Glasses (Child)
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care
- Hearing Aides

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You may 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. For more information on your rights to continue coverage, contact the claims administrator at 1-800-634-0173 or the plan at 1-336-719-2729.

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 1-336-719-2729. 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**.
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 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.

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	$5,000
Specialist copayment	$60
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$5,000
Copayments	$0
Coinsurance	$3,850
What is not covered	
Limits or exclusions	$0
The total Peg would pay is	**$8,150**

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

The plan's overall deductible	$5,000
Specialist copayment	$60
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$5,000
Copayments	$150
Coinsurance	$225
What is not covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,375**

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

The plan's overall deductible	$5,000
Specialist copayment	$60
Hospital (facility) coinsurance	50%
Other coinsurance	50%

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	$1,925
Copayments	$0
Coinsurance	$0
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

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