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, Catilize Health at 877-872-4232. 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 1-877-872-4232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	
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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not Applicable	Any procedure not covered by Alternate Coverage will not be reimbursed under this plan.
Do you need a referral to see a specialist?	Indirectly only	This plan does not reimburse for expenses not paid by the Alternate Coverage, and the Alternate Coverage may use a network of providers.

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	$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to $9,200/single and $18,400/family per year. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Specialist visit	$0	$0	
	Preventive care/screening/ immunization	$0	$0	
If you have a test	Diagnostic test (x-ray, blood work)	$0	$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to $9,200/single and $18,400/family per year. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Imaging (CT/PET scans, MRIs)	$0	$0	
If you need drugs to treat your illness or condition	Generic drugs	$0	$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to $9,200/single and $18,400/family per year. Any drug not covered by the Alternate Coverage will not be reimbursed under this plan.
	Preferred brand drugs	$0	$0	
	Non-preferred brand drugs	$0	$0	
	Specialty drugs	$0	$0	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0	$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles

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

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)	
	Physician/surgeon fees	$0	$0	incurred under the Alternate Coverage up to $9,200/single and $18,400/family per year. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
If you need immediate medical attention	Emergency room care	$0	$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to $9,200/single and $18,400/family per year. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Emergency medical transportation	$0	$0	
	Urgent care	$0	$0	
If you have a hospital stay	Facility fee (e.g., hospital room)	$0	$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to $9,200/single and $18,400/family per year. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Physician/surgeon fees	$0	$0	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0	$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to $9,200/single and $18,400/family per year. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Inpatient services	$0	$0	
If you are pregnant	Office visits	$0	$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible

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

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)	
	Childbirth/delivery professional services	$0	$0	co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to $9,200/single and $18,400/family per year. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Childbirth/delivery facility services	$0	$0	
If you need help recovering or have other special health needs	Home health care	$0	$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to $9,200/single and $18,400/family per year. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Rehabilitation services	$0	$0	
	Habilitation services	$0	$0	
	Skilled nursing care	$0	$0	
	Durable medical equipment	$0	$0	
	Hospice services	$0	$0	
If your child needs dental or eye care	Children's eye exam	Not Covered		Not Covered
	Children's glasses			
	Children's dental check-up			

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
- Any expense payable through another source (such as the Alternate Coverage)
- Bariatric surgery
- Chiropractic care
- Cosmetic Surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

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

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

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: 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 the plan at 1-877-872-4232. 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
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? No, however, this plan is integrated with a group health plan that may meet the minimum value standards. 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.

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	**$N/A**
Specialist *[cost sharing]*	**$N/A**
Hospital (facility) *[cost sharing]*	**%N/A**
Other *[cost sharing]*	**%N/A**

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	$N/A
Copayments	$N/A
Coinsurance	$N/A
What isn't covered	
Limits or exclusions	$N/A
The total Peg would pay is	**$N/A**

This plan does not cover specific services, it only pays for eligible co-pays, co-insurance and deductibles up to the amount available in the Spousal Advantage Plan

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

The plan's overall deductible	**$N/A**
Specialist *[cost sharing]*	**$N/A**
Hospital (facility) *[cost sharing]*	**%N/A**
Other *[cost sharing]*	**%N/A**

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	$N/A
Copayments	$N/A
Coinsurance	$N/A
What isn't covered	
Limits or exclusions	$N/A
The total Joe would pay is	**$N/A**

This plan does not cover specific services, it only pays for eligible co-pays, co-insurance and deductibles up to the amount available in the Spousal Advantage Plan

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

The plan's overall deductible	**$N/A**
Specialist *[cost sharing]*	**$N/A**
Hospital (facility) *[cost sharing]*	**%N/A**
Other *[cost sharing]*	**%N/A**

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	$N/A
Copayments	$N/A
Coinsurance	$N/A
What isn't covered	
Limits or exclusions	$N/A
The total Mia would pay is	**$N/A**

This plan does not cover specific services, it only pays for eligible co-pays, co-insurance and deductibles up to the amount available in the Spousal Advantage Plan

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