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, www.acuity-grp.com or 1-866-569-6092. 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.cciio.cms.gov or call 1-888-866-5311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 individual / $1,000 family. Copayments do not count towards reaching your annual 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 is 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. 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 deductible specific services.
What is the out-of-pocket limit for this plan?	$1,000 individual / $2,000 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?	Premiums, prior authorization/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?	Not Applicable.	This plan does not use a provider network. You are encouraged to submit a Provider Nomination to ClaimDOC before your first appointment so they may educate your provider.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a DPC referral before you see the specialist.

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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Includes x-rays, tests, inoculations, lab work performed in the provider's office at the time of the appointment. Does not include MRIs, other non-X-ray imaging test, surgery, or chemotherapy.
	Specialist visit	$50 copayment/office visit	A referral from a Direct Primary Care Physician to a Primary Care Physician or a Specialist is required except to the extent required by the Affordable Care Act. I Includes x-rays, tests, inoculations, lab work performed in the provider's office at the time of the appointment. Does not include MRIs, other non-X-ray imaging test, surgery, or chemotherapy.
	Preventive care/screening/ immunization	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Frequency limits apply.
If you have a test	Diagnostic test (x-ray, blood work)	$0 copayment if ordered by DPC doctor, then 10% coinsurance	DPC referral and Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Imaging (CT/PET scans, MRIs)	$0 copayment if ordered by DPC doctor, then 10% coinsurance	DPC referral and Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.truescripts.com or 1-844-257-1955.	Generic drugs	$15 copayment for up to 30-day supply; $30 copayment for up to 90-day supply through mail order pharmacy	
	Preferred brand drugs	$35 copayment for up to 30-day supply; $70 copayment for up to 90-day supply through mail order pharmacy	
	Non-preferred brand drugs	$50 copayment for up to 30-day supply; $100 copayment for up to 90-day supply through mail order pharmacy	

[* For more information about limitations and exceptions, see the plan or policy document at www.acuity-grp.com.]

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Specialty drugs Tier 1 Specialty drugs Tier 2 Specialty drugs Tier 3 Specialty drugs Tier 4 Specialty drugs Tier 5	$50 copayment for up to 30-day supply 20% copayment up to $550.00 maximum 20% copayment up to $2,000.00 maximum 20% copayment 50% copayment	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 copayment if ordered by DPC doctor, otherwise, then 10% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Physician/surgeon fees	$0 copayment if ordered by DPC doctor, then 10% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
If you need immediate medical attention	Emergency room care	$250 copayment	
	Emergency medical transportation	$0 copayment if ordered by DPC doctor, then 10% coinsurance	Only covered if a "prudent" layperson would consider usage appropriate.
	Urgent care	$75 copayment applies unless sent to ER from urgent care.	Includes routine services (X-rays, surgery, etc.) performed on the same day by same provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment , then 10% coinsurance	DPC referral and Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Physician/surgeon fees	$500 copayment , then 10% coinsurance	DPC referral and Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copayment if ordered by DPC doctor, then 10% coinsurance	DPC referral and Preauthorization is required. If you don't get and preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Inpatient services	$500 copayment , then 10% coinsurance	DPC referral and Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
If you are pregnant	Office visits	No charge	DPC referral and Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service. A referral from a Direct Primary Care Physician to a Primary Care Physician or a Specialist is required
	Childbirth/delivery professional services	$0 copayment if ordered by DPC doctor, otherwise, $500 copayment applies	
	Childbirth/delivery facility	$0 copayment if ordered by DPC doctor,	

[* For more information about limitations and exceptions, see the plan or policy document at www.acuity-grp.com.]

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	services	otherwise, $500 copayment applies	except to the extent required by the Affordable Care Act. Maternity Benefits are not covered for enrolled dependent children.
If you need help recovering or have other special health needs	Home health care	$0 copayment if ordered by DPC doctor, then 10% coinsurance	DPC referral and Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Rehabilitation services	$0 copayment if ordered or performed by DPC doctor. Otherwise, if office-based, $0 copayment for first 12 visits during the Plan Year; thereafter, $25 copayment. If hospital-based, deductible applies until met, then 10% coinsurance	DPC referral and Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Habilitation services	$0 copayment if ordered or performed by DPC doctor, otherwise $50 copayment applies.	DPC referral and Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Skilled nursing care	$0 copayment if ordered by DPC doctor, then 10% coinsurance applies.	DPC referral and Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Durable medical equipment	$0 copayment if ordered by DPC doctor, then 10% coinsurance applies.	DPC referral and Preauthorization is required if over $500. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service. If referred to DME Connect, waiver of cost may be applied.
	Hospice services	No charge	DPC referral and Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	N/A
	Children's glasses	Not covered	N/A
	Children's dental check-up	Not covered	N/A

[* For more information about limitations and exceptions, see the plan or policy document at www.acuity-grp.com.]

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- 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.)

- Acupuncture
- Chiropractic care
- Infertility treatment
- Private-duty nursing
- Routine foot care

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: 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 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 sponsor at 1-914-241-4999 or the plan's Claims processor at 1-866-569-6092, or the U. S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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 1-866-569-6092.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-569-6092.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-569-6092.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-569-6092.]

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.acuity-grp.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 pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist *Copayment*	$50
Hospital (facility) *Coinsurance*	10%
Other *Coinsurance*	10%

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	$500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

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

The plan's overall deductible	$500
Specialist *Copayment*	$50
Hospital (facility) *Coinsurance*	10%
Other *Coinsurance*	10%

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	$500
Copayments	$400
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$990**

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

The plan's overall deductible	$500
Specialist *Copayment*	$50
Hospital (facility) *Coinsurance*	10%
Other *Coinsurance*	10%

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	$500
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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