Subject to plan allowable **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, go to www.detegohealth.com or call 1-866-815-6001. 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.com or www.cciio.cms.gov

Important Questions	Answers	Why This Matters:
What is the overall deductible?	None	There is no deductible for this plan.
Are there services covered before you meet your deductible?	Yes	There is no deductible for this plan.
Are there other deductibles for specific services?	None	There is no deductible for this plan.
What is the out-of-pocket limit for this plan?	None	There is no out-of-pocket for this plan.
What is not included in the out-of-pocket limit?	Not applicable	There is no out-of-pocket for this plan.
Will you pay less if you use a network provider?	No network restrictions.	There are no network restrictions for this plan.
What is the yearly benefit maximum?	$500,000.00	There is a $500,000.00 per member, per Plan year maximum.
What is the lifetime benefit maximum?	$2,500,000.00	There is a $2,500,000.00 per member, per Lifetime maximum.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

Common Medical Event	Services You May Need	Member out of pocket	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 (10 per benefit period)	$50 copay/visit	10 visit per benefit period maximum is combined for PCP office visits, Specialist office visits, and Urgent Care visits.
	Specialist visit	$50 copay/visit	10 visit per benefit period maximum is combined for PCP office visits, Specialist office visits, and Urgent Care visits.
	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. Services are limited to those covered by the Affordable Care Act. All services must be conducted in office, hospital services are not covered.
	Tele-Medicine	No charge	Unlimited
If you have a test	Diagnostic test (X-ray) (3 per benefit period)	$50 copay per visit	3 per benefit period maximum.
	Diagnostic test (lab) (3 per benefit period)	$50 copay per visit	3 per benefit period maximum.
	Imaging (CT/PET scans, MRIs, MRAs) (3 per benefit period)	$250 copay per visit	3 per benefit period maximum.
If you need drugs to treat your illness or condition More information about Prescription Drug Coverage is available at https://detegohealth.com/resources/ under the Formulary section.	Generic drugs	Ventegra	None
	Preferred brand drugs	Not covered	
	Non-preferred brand drugs	Not covered	
	Specialty drugs	Not covered	None
If you have outpatient surgery	Outpatient Hospital/Ambulatory Surgical Center, All fees	$250 copay/surgery	None
If you need immediate medical attention	Emergency room care	$250 copay/visit	2 visit limit per benefit period for Accident related visits. 2 visit limit per benefit period for Sickness related visits.
	Emergency medical transportation	No charge	2 visit per benefit period maximum. Combined for Ground and Air ambulance services.

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

	Urgent care (10 per benefit period)	$50 copay/visit	10 visit per benefit period maximum is combined for PCP office visits, Specialist office visits, and Urgent Care visits.
Common Medical Event	**Services You May Need**	**Member out of pocket**	**Limitations, Exceptions, & Other Important Information**
If you have a hospital stay	Inpatient Hospital Services, Facility/Physician fees	$1,000 copay/admission	Paid at facility's semi-private room rate. Non-ICU stays limited to 2 hospitalizations per benefit period. ICU stays limited to 3 hospitalizations per benefit period. 10 day limit per hospitalization.
	Inpatient Hospital Surgical Services, All fees	$1,000 copay/surgery	2 surgeries per Plan year.
If you need mental health, behavioral health and substance abuse services	Outpatient services	No Coverage	None
	Inpatient services	$250 copay/admission	Includes Facility and Professional Fees
If you are pregnant	Global Maternity Services, All Fees	Vaginal delivery: $250 copay/admission C-Section delivery: $500 copay/admission Other maternity services: No charge	Other maternity services include office visits, lab work, radiology, prenatal/postnatal care, etc.
If you need help recovering or have other special health needs	Home health care	$50 copay/visit	$500 maximum per benefit period.
	Therapies (Chiropractic, PT/OT/ST, Cardiac)	$50 copay/visit	5 visit limit per benefit period maximum for each type of therapy. Chiropractic x-rays are covered.
	Skilled nursing care	$50 copay/day	$5,000 maximum per benefit period.
	Durable medical equipment	$50 copay/item	$500 maximum per benefit period. Copayment is applied per item received.
	Infusion/Injection drugs	$100 copay/visit	
	Diabetic Nutritional Counseling	No charge	
	Allergy testing/shots	$50 copay/visit	
	Dialysis	Not covered	
	Organ Transplant Services	Not covered	
	Prosthetics	$50 copay/item	$2,500 maximum per benefit period. Copayment is applied per item received.
	Diabetic supplies/equipment	No charge	
	Chemotherapy	$100 copay/visit	
	Hospice services	No charge	$5,000 maximum per benefit period.
If your child needs	Child Eye exam	Not covered	
	Child Glasses	Not covered	

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

dental or eye care	Child Dental check-up	Not covered	

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.)

- Accupuncture
- Children's Dental Check-up
- Children's Glasses
- Children's Eye Exam
- Dialysis
- Biofeedback
- Mental Health Services
- Substance Abuse Services

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

- Annual Lab / X-Ray Tests
- Annual Pap Smear / Mammogram
- Cancer Screenings
- Colonoscopies
- Diabetic Supply
- Immunizations
- Other Preventative Screenings
- Prescriptions
- Tele-Medicine
- Urgent care and office visits
- Well Baby Care
- Wellness Visits

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 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: Performance Health at 866-815-6001 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform

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 [866-815-6001]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [866-815-6001]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[866-815-6001]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [866-815-6001]

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.detegohealth.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	$0.00
Specialist	No charge
Hospital (facility, c-section)	$1,000
Other	No Coverage

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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,000**

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

Specialist	$50
Diagnostic testing	$50
Other	$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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$150**

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

The plan's overall deductible	$0.00
Specialist	$250
Hospital (facility)	$50
Other	$50

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$350**

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