

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](http://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](http://www.dol.gov/ebsa/healthreform.com) or [www.cciio.cms.gov](http://www.cciio.cms.gov)

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	Individual \$500 / Family Unit \$1,000	You will have to cover the first \$500 / \$1,000 for all services.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes	No benefits before deductible is met.
Are there other <a href="#">deductibles</a> for specific services?	None	There is no deductible for this plan.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	None	There is no out-of-pocket for this plan.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not applicable	There is no out-of-pocket for this plan.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, you will pay less if you use network providers.	There are no network restrictions for this plan.
What is the yearly benefit maximum?	\$1,000,000	There is a \$1,000,000 per member, per Plan year maximum.
What is the lifetime benefit maximum?	\$5,000,000	There is a \$5,000,000 per member, per lifetime maximum.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No. You don't need a referral to see a specialist.	You can see the <a href="#">specialist</a> you choose without permission from this plan.

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness (10 per benefit period)	\$50 <a href="#">copay</a> /visit (after deductible)	10 visit per benefit period maximum is combined for PCP office visits, Specialist office visits, and Urgent Care visits.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit (after deductible)	10 visit per benefit period maximum is combined for PCP office visits, Specialist office visits, and Urgent Care visits.
	<a href="#">Preventive care/screening/</a> Immunization.	No charge	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . 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 – General Medicine Tele-Medicine – Mental Health Tele-Medicine – Urgent Care	No charge on all Tele-Medicine when you use the MyLiveDoc Platform.	12 visits limit per benefit year. Includes Dermatology. 4 visits limit per benefit year. Unlimited through Tele-Medicine Platform.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (X-Ray, Lab, EKGs, ECGs, All other diagnostic services not included in Imaging) (3 per benefit period)	\$50 <a href="#">copay</a> per visit (after deductible)	3 per benefit period maximum.
	Imaging (CT/PET scans, MRIs, MRAs) (3 per benefit period)	\$250 copay per visit (after deductible)	3 per benefit period maximum.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mylivepharmacy.com">www.mylivepharmacy.com</a>	Generic drugs	Limited	Please see your Tele-Medicine Formulary
	Preferred brand drugs	Limited	Please see your Tele-Medicine Formulary
	Non-preferred brand drugs	Not covered	None

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
	<u>Specialty drugs</u>	Not covered	None
<b>If you have outpatient surgery</b>	Outpatient Hospital/Ambulatory Surgical Center, All fees	\$250 copay/surgery (after deductible)	3 Surgeries Per Plan Year limit.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$250 copay/visit (after deductible)	2 visit limit per benefit period for Accident related visits. 2 visit limit per benefit period for Sickness related visits.
	<u>Emergency medical transportation</u>	No charge	2 visit per benefit period maximum. Combined for Ground and Air ambulance services.
	<u>Urgent care (10 per benefit period)</u>	\$50 <u>copay</u> /visit (after deductible)	10 visit per benefit period maximum is combined for PCP office visits, Specialist office visits, and Urgent Care visits.
<b>If you have a hospital stay</b>	Inpatient Hospital Services, Facility/Physician fees	\$1,000 copay/admission (after deductible)	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 (after deductible)	2 surgeries per Plan year.
<b>If you need mental health, behavioral health and substance abuse services</b>	Outpatient services	No Coverage	None
	Inpatient services	\$250 copay/admission (after deductible)	Includes Facility and Professional Fees Included in the inpatient hospitalization limit.
<b>If you are pregnant</b>	Global Maternity Services, All Fees	\$250 copay per admission, Vaginal delivery \$500 copay per admission, C-Section delivery 100% coverage for other maternity services	Other maternity services include office visits, lab work, radiology, prenatal/postnatal care, etc. Capped at \$15,000 Per Plan Year. Excludes Genetic testing unless medically necessary.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	\$50 copay/visit (after deductible)	\$500 maximum per benefit period.
	Therapies (Chiropractic, PT/OT/ST, Cardiac) (Precertification Required)	\$50 copay/visit (after deductible)	10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits, Therapies (Chiropractic, PT/OT/ST, Cardiac), Mental Health/Behavioral Health/Autism/Substance Abuse office visits.
	<u>Skilled nursing care</u>	\$50 copay/day (after deductible)	\$5,000 maximum per benefit period.

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
	<u>Durable medical equipment</u>	\$50 copay/item (after deductible)	\$500 maximum per benefit period. Copayment is applied per item received.
	Infusion/Injection drugs	\$100 copay/visit (after deductible)	\$50,000 Benefit Max Per Plan Year. Maximum combined with chemotherapy/radiation benefit.
	Diabetic Nutritional Counseling	No charge (after deductible)	1 visit per plan year
	Allergy visits/testing	\$100 copay/visit (after deductible)	4 visit per plan year
	Allergy shots	\$25 copay/visit (after deductible)	25 visit per plan year
	Prosthetics	\$50 copay/item (after deductible)	\$2,500 maximum per benefit period. Copayment is applied per item received.
	Diabetic supplies/equipment	DiaThrive: \$35/Month Non-DiaThrive	See DiaThrive information for more details. \$250 Max Per Plan Year (after deductible)
	Chemotherapy/Radiation	\$100 copay/visit (after deductible)	\$50,000 Benefit Max Per Plan Year. Maximum combined with infusion and injections drugs benefit.
	<u>Hospice services</u>	No charge (after deductible)	\$5,000 maximum per benefit period.
	Dialysis	Not covered	
	Organ Transplant Services	Not covered	
<b>If your child needs dental or eye care</b>	Child Eye exam	Not covered	
	Child Glasses/Contacts	Not covered	
	Child Dental check-up	Not covered	

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Accupuncture</li> <li>• Children's Dental Check-up</li> <li>• Children's Glasses/Contacts</li> </ul>	<ul style="list-style-type: none"> <li>• Children's Eye Exam</li> <li>• Dialysis</li> <li>• Biofeedback</li> </ul>	<ul style="list-style-type: none"> <li>• Mental Health Services (except for Telemedicine)</li> <li>• Substance Abuse Services</li> <li>• Organ Transplant Services</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Annual Lab / X-Ray Tests</li> <li>• Annual Pap Smear / Mammogram</li> <li>• Cancer Screenings</li> <li>• Colonoscopies</li> </ul>	<ul style="list-style-type: none"> <li>• Diabetic Supply</li> <li>• Immunizations</li> <li>• Other Preventative Screenings</li> <li>• Precision Rx (Prescriptions)</li> </ul>	<ul style="list-style-type: none"> <li>• Tele-Medicine (Including Mental Health)</li> <li>• Urgent care and office visits</li> <li>• Well Baby Care</li> <li>• Wellness Visits</li> </ul>

**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](http://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](http://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](http://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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' [866-815-6001]

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a>	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*)

<b>Total Example Cost</b>	<b>\$7,540</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,000</b>

### Managing Joe's type 2 Diabetes

(a year of routine care of a well-controlled condition)

■ <a href="#">Specialist</a>	\$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*)

<b>Total Example Cost</b>	<b>\$5,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$50
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$550</b>

### Mia's Simple Fracture

(emergency room visit and follow up care)

The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a>	\$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*)

<b>Total Example Cost</b>	<b>\$2,500</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$150
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$650</b>