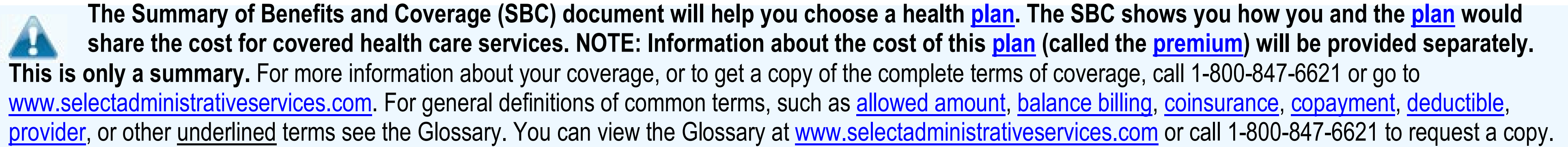

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-847-6621 or go to www.selectadministrativeservices.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.selectadministrativeservices.com or call 1-800-847-6621 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers $7,350 person / $14,700 family; for out-of-network providers $14,700 person / $29,400 family	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. Out-of-network charges are paid according to Select Administrative Services' fee schedule.
Are there services covered before you meet your deductible?	Yes. Preventive care and medical services with copayments 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. 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	None.
What is the out-of-pocket limit for this plan?	For in-network providers $7,350 person / $14,700 family; unlimited for out-of-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. Out-of-network charges are paid according to Select Administrative Services' fee schedule.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain precertification, services in excess of Plan maximums or limits, premiums, balance-billing charges, 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?	Yes. See www.selectadministrativeservices.com or call 800-847-6621 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 a referral.

All **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
		In-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	$50 copay/office visit; 100% coinsurance other physician services.	50% coinsurance	Copay applies to exam charge only. Limited to General Practice, Family Practice, OB/GYN, Internal Medicine, Osteopaths, Pediatricians and Mental Health Providers. Chiropractic coverage is limited to 20 visits. Deductible does not apply to office visit and other services in the office of network providers.
	Specialist visit	$100 copay/office visit; 100% coinsurance other physician services.	50% coinsurance	Copay applies to exam charge only. Deductible does not apply to office visit and other services in the office of network providers.
	Preventive care/screening/ immunization	No charge (deductible does not apply).	50% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	100% coinsurance if not done in office; In office there is no charge and deductible does not apply.	50% coinsurance	Deductible does not apply to independent labs and other services in the office of network providers. Services provided in the Provider's office may be subject to the amounts listed above for Primary or Specialist care.
	Imaging (CT/PET scans, MRIs)	100% coinsurance	50% coinsurance	PET Scans must be pre-certified in order to avoid a 50% penalty, per occurrence.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ProArt.com.	Tier 1 Drugs	$25 copay /prescription (retail 30-day) $55 copay /prescription (mail-order 90-day) $75 copay /prescription (retail 90-day)		Tier 1 drugs are brand and generic medicines that have a retail fill cost of up to $100 for a 30-day supply. Tier 2 drugs are brand and generic medicines that have a retail fill cost of between $101 and $250 for a 30-day supply. Tier 3 drugs are brand and generic medicines that have a retail fill cost of $251 and greater for a 30-day supply. Prior authorization is required for all Tier 3 and specialty drugs. To obtain prior approval, please call SAS at 1-800-847-6621 or go to www.ProArt.com and complete the prior authorization form.
	Tier 2 Drugs	$40 copay /prescription (retail 30-day) $100 copay /prescription (mail-order 90-day) $120 copay /prescription (retail 90-day)		
	Tier 3 Drugs	$75 copay /prescription (retail 30-day) $175 copay /prescription (mail-order 90-day) $225 copay /prescription (retail 90-day)		

*For more information about limitations and exceptions, see plan document at www.selectadministrativeservices.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				Certain Prescription drugs may be subject to prior authorization, quantity limits, day limits and/or duration of use restrictions. Mail order is required after first retail fill on eligible chronic medications to receive 90-day discounted rate. If filled at local pharmacy, cost will reflect 30-day cost x 3. For a complete description of the prescription drug coverage offered by this plan, including the use of Patient Assistance Programs and International Pharmacies, see Schedule of Medical Benefits in plan document.
	Specialty drugs	50% coinsurance to a max of a $250 copay /prescription level. Members are required to file for PAP and International via ProAct PBM to receive copay pricing. If members elect to not file with Shield PBM, specialty pricing will be at the 50% coinsurance of actual cost level.		*Please see Prescription Drug Benefit section within your Plan Document for details. All specialty drugs require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% coinsurance	50% coinsurance	None.
	Physician/surgeon fees	100% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	100% coinsurance		A $350 Co-payment will be applied for non-emergency services.
	Emergency medical transportation	100% coinsurance	50% coinsurance	None.
	Urgent care	$50 / primary care or $100 / specialist office visit; Deductible does not apply.	50% coinsurance	Other Covered Services rendered in the Network Provider's office will be subject to the Network Co-insurance amount.
If you have a hospital stay	Facility fee (e.g., hospital room)	100% coinsurance	50% coinsurance	Inpatient Rehabilitation Services are limited to 30 days per year and not covered if services received from Non-Network Provider. Services must be pre-certified in order to avoid a 50% penalty, per occurrence.
	Physician/surgeon fees	100% coinsurance	50% coinsurance	None.

*For more information about limitations and exceptions, see plan document at www.selectadministrativeservices.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	$50 / office visit; 100% coinsurance for Outpatient services.	40% coinsurance	Other Covered Services rendered in the Network Provider's office will be subject to the Network Co-insurance amount with the Deductible waived. Subject to Care Management, Medical Necessity, and appropriateness of care. Inpatient services must be pre-certified in order to avoid a 50% penalty, per occurrence. Not covered if Patient is discharged against medical advice.
	Inpatient services	100% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$50 copay/office visit	50% coinsurance	Deductible does not apply to other services in the office of network providers. Cost sharing does not apply to certain preventive services. Depending on the type of services, a Copayment, Coinsurance, or Deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	100% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	100% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	100% coinsurance	50% coinsurance	Services must be pre-certified in order to avoid a 50% penalty, per occurrence.
	Rehabilitation services	100% coinsurance	50% coinsurance	Physical and occupational therapy: all services rendered by physical therapist/occupational therapists are limited to a combined maximum of 20 visits of office and outpatient facility services per calendar year. Speech therapy: limited to 20 visits maximum per calendar year.
	Habilitation services			
	Skilled nursing care	Not Covered	Not Covered	None.
	Durable medical equipment	100% coinsurance	50% coinsurance	Pre-certification is required for all rentals & purchase price over $500 to avoid a 50% penalty, per occurrence.
	Hospice services	100% coinsurance	50% coinsurance	Includes Respite Care for family members caring for a terminally ill patient. Respite Care must be used in increments of not more than five days at a time. 6-month lifetime limitation.
If your child needs dental or eye care	Children's eye exam	$40 / visit	Not Covered	Applies from birth through age 5. Limit one per year.
	Children's glasses	Not covered	Not covered	Not covered.

*For more information about limitations and exceptions, see plan document at www.selectadministrativeservices.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

- Acupuncture (in lieu of anesthesia)
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)- age 21 and over
- Routine Foot Care
- Weight Loss Programs (non-surgical obesity treatment)

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

- Chiropractic Care (limited to 20 visits per calendar year)
- Infertility treatment (except promotion of conception)
- Private-duty nursing

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: Select Administrative Services at 1-800-847-6621 or visit us at www.selectadministrativeservices.com or 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.

*For more information about limitations and exceptions, see plan document at www.selectadministrativeservices.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 in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$7,350**
- **Specialist copayment** **$100**
- **Hospital (facility) coinsurance** **100%**
- **Other coinsurance** **100%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,250
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,210**

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

- **The plan's overall deductible** **$7,350**
- **Specialist copayment** **$100**
- **Hospital (facility) coinsurance** **100%**
- **Other coinsurance** **100%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Prescription drug supplies *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,862
Copayments	$2,345
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,262**

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

- **The plan's overall deductible** **$7,350**
- **Specialist copayment** **$100**
- **Hospital (facility) coinsurance** **100%**
- **Other coinsurance** **100%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,632
Copayments	$240
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,872**

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