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 1-844-234-4472. 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.healthcare.gov/sbc-glossary.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,300 person/$6,600 family. Doesn't apply to preventative care. For non-participating providers $5,000 person/ $10,000 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.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	For participating providers $3,500 person/ $7,000 family. For non-particpating providers $10,000 person/$20,000 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, difference between billed and allowed amounts, healthcare this plan doesn't cover, and ineligible expenses.	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.MotivHealth.com** or call **1-844-234-4472** for a list of participating 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 **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	20% After Deductible	50% AfterDeductible	
	Specialist visit	20% After Deductible	50% AfterDeductible	
	Preventive care/ screening/immunization	No charge	No charge up to allowed amount	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% After Deductible	50% AfterDeductible	
	Imaging (CT/PET scans, MRIs)	20% After Deductible	50% AfterDeductible	Prior authorization applies
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.motivhealth.com	Generic drugs	20% After Deductible	N/A	
	Preferred brand drugs	20% After Deductible	N/A	
	Non-preferred brand drugs	20% After Deductible	N/A	
	Specialty drugs	20% After Deductible	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% After Deductible at Hospital 10% After Deductible at Ambulatory Surgical Center	50% AfterDeductible	
	Physician/surgeon fees	20% After Deductible	50% AfterDeductible	
If you need immediate medical attention	Emergency room care	20% After Deductible	20% After Deductible	Out-of-network utilization of these benefits will apply to in network benefits up to allowed amount
	Emergency medical transportation	20% After Deductible up to a maximum of $500	20% After Deductible up to a maximum of $500	Out-of-network utilization of these benefits will apply to in network benefits up to allowed amount
	Urgent care	20% After Deductible	50% AfterDeductible	

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 have a hospital stay	Facility fee (e.g., hospital room)	20% After Deductible	50% AfterDeductible	Pre-cert is required except for maternity care.
	Physician/surgeon fees	20% After Deductible	50% AfterDeductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% After Deductible	50% AfterDeductible	Facility charges require prior authorization.
	Inpatient services	20% After Deductible	50% AfterDeductible	
If you are pregnant	Office visits	20% After Deductible	50% AfterDeductible	
	Childbirth/delivery professional services	20% After Deductible	50% AfterDeductible	Home births are not covered.
	Childbirth/delivery facility services	20% After Deductible	50% AfterDeductible	Home births are not covered.
If you need help recovering or have other special health needs	Home health care	20% After Deductible	50% AfterDeductible	
	Rehabilitation services	20% After Deductible	50% AfterDeductible	Limited to 60 visits per year combined between Physical Therapy, Occupational Therapy and Speech Therapy.
	Chiropractic services	20% After Deductible	50% AfterDeductible	Limited to 25 visits per year
	Habilitation services	20% After Deductible	50% AfterDeductible	Limited to 60 visits per year combined between Physical Therapy, Occupational Therapy and Speech Therapy.
	Skilled nursing care	20% After Deductible	50% AfterDeductible	Limited to 60 visits per year combined between Physical Therapy, Occupational Therapy and Speech Therapy.
	Durable medical equipment	20% After Deductible	50% AfterDeductible	
	Hospice services	20% After Deductible	50% AfterDeductible	
If you need eye care	Eye exam	No charge	50% AfterDeductible	Limited to one exam per year.
	Children's glasses	Not covered	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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- 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

For more information about limitations and exceptions, see the plan or policy document at www.MotivHealth.com or call 1-844-234-4472.

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 year

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 the Department of Labor's Employee Benefits Security Administration 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 1-801-318-2596.

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 MotivHealth at 1-844-234-4472 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**

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 1-844-234-4472.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-234-4472.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-234-4472.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-234-4472.]

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

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	$3,300
Specialist	20%
Hospital (facility)	20%
Other	20%

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	$3,300
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,800**

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

The plan's overall deductible	$3,300
Specialist	20%
Hospital (facility)	20%
Other	20%

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	$3,300
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,800**

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

The plan's overall deductible	$3,300
Specialist	20%
Hospital (facility)	20%
Other	20%

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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