
 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, contact Tall Tree Administrators. 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.talltreehealth.com](http://www.talltreehealth.com) or call 1-877-453-4201 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network providers</a> \$600 individual / \$1,200 family; for <a href="#">out-of-network providers</a> \$1,200 individual / \$2,400 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$4,500 individual / \$6,750 family; for <a href="#">out-of-network providers</a> \$9,000 individual / \$14,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.talltreehealth.com">www.talltreehealth.com</a> or call 1-877-453-4201 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No. You do not need a referral to see a specialist.	You can see the specialist you choose without permission from the plan.

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	Per Plan Provisions
	<a href="#">Specialist</a> visit	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	Per Plan Provisions
	<a href="#">Preventive care/screening/immunization</a>	No charge	<a href="#">Deductible</a> , then 60% of allowed amount	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 preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	Per Plan Provisions
	Imaging (CT/PET scans, MRIs)	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	* <a href="#">Pre-Certification</a> Required. Failure to obtain prior authorization may result in a penalty of \$200 or denial of benefits.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> /prescription (retail & mail order)	No Benefit	Covers a 30-90-day supply (retail prescription); 90-day supply (mail order prescription).  Specialty Drugs limited to 30-day prescription
	Preferred brand drugs (Tier 2)	\$30 <a href="#">copay</a> /prescription (retail) \$60 <a href="#">copay</a> /prescription (mail order)	No Benefit	
	Non-preferred brand drugs (Tier 3)	\$50 <a href="#">copay</a> /prescription (retail) \$150 <a href="#">copay</a> /prescription (mail order)	No Benefit	
	<a href="#">Specialty drugs</a> (Tier 4)	\$100 <a href="#">copay</a> /prescription	No Benefit	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	* <a href="#">Pre-Certification</a> Required. Failure to obtain prior authorization may result in a penalty of \$200 or denial of benefits.
	Physician/surgeon fees	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	Per Plan Provisions
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> /visit	\$250 <a href="#">copay</a> /visit	Per Plan Provisions
	<a href="#">Emergency medical transportation</a>	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 40% of allowed amount	

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)	
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	\$100 <a href="#">copay</a> /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 <a href="#">copay</a> , <a href="#">deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	* <a href="#">Pre-Certification</a> Required. Failure to obtain prior authorization may result in a penalty of \$200 or denial of benefits.
	Physician/surgeon fees	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	Per Plan Provisions
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	Per Plan Provisions
	Inpatient services	\$300 <a href="#">copay</a> , <a href="#">deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	* <a href="#">Pre-Certification</a> Required. Failure to obtain prior authorization may result in a penalty of \$200 or denial of benefits.
If you are pregnant	Office visits	No Charge	<a href="#">Deductible</a> , then 60% of allowed amount	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	
	Childbirth/delivery facility services	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	Limited to 60 visits/benefit plan year
	<a href="#">Rehabilitation services</a>	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	Physical Therapy Limited to 40 visits. Occupational and Speech therapy limited to 20 visits per plan year.
	<a href="#">Habilitation services</a>	No Benefit	No Benefit	Per Plan Provisions
	<a href="#">Skilled nursing care</a>	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	* <a href="#">Pre-Certification</a> Required. Failure to obtain prior authorization may result in a penalty of \$200 or denial of benefits.
	<a href="#">Durable medical equipment</a>	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	<a href="#">Deductible</a> , then 40% <a href="#">coinsurance</a>	<a href="#">Deductible</a> , then 60% of allowed amount	Per Plan Provisions
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Coverage limited to one exam/year.
	Children's glasses	Not Covered	Not Covered	Please see Vision Plan if applicable
	Children's dental check-up	Not Covered	Not Covered	Please see Dental Plan if applicable

### 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](#).)

- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)

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

- Chiropractic 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](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323, extension 61565 or [www.cciio.cms.gov](http://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](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: [Tall Tree Administrators – 877-453-4201].

**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](#).

### Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-877-453-4201.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-453-4201.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-453-4201.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-453-4201.]

-----*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](#) \$600
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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>\$12,731</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$340
Coinsurance	\$1455
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2455</b>

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

- The [plan's](#) overall [deductible](#) \$600
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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>\$7,390</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$600
Copayments	\$700
Coinsurance	\$1170
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2526</b>

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

- The [plan's](#) overall [deductible](#) \$600
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$600
Copayments	\$0
Coinsurance	\$547
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1147</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: **NOT APPLICABLE**

\*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.