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 or call 1-877-453-4201 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $600 individual / $1200 family; for out-of-network providers $1,200 individual / $2,400 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.
Are there services covered before you meet your deductible?	Yes. Preventive care services 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.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $4,500 individual / $6,750 family; for out-of-network providers $9,000 individual / $14,000 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, 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.talltreehealth.com or call 1-877-453-4201 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 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 provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	Per Plan Provisions
	Specialist visit	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	Per Plan Provisions
	Preventive care/screening/ immunization	No charge	Deductible, then 50% of allowed amount	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)	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	Per Plan Provisions
	Imaging (CT/PET scans, MRIs)	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	*Pre-Certification 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 prescription drug coverage is available at www.optumrx.com	Generic drugs (Tier 1)	$10 copay/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 copay/prescription (retail) $60 copay/prescription (mail order)	No Benefit	
	Non-preferred brand drugs (Tier 3)	$50 copay/prescription (retail) $150 copay/prescription (mail order)	No Benefit	
	Specialty drugs (Tier 4)	$100 Copay/prescription	No Benefit	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	*Pre-Certification Required. Failure to obtain prior authorization may result in a penalty of $200 or denial of benefits.
	Physician/surgeon fees	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	Per Plan Provisions
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	Per Plan Provisions
	Emergency medical	Deductible, then 30%	Deductible, then 30% of	

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)	
	transportation	coinsurance	allowed amount	
	Urgent care	$50 copay/visit	$100 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay, deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	*Pre-Certification Required. Failure to obtain prior authorization may result in a penalty of $200 or denial of benefits.
	Physician/surgeon fees	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	Per Plan Provisions
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	Per Plan Provisions
	Inpatient services	$300 copay, deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	*Pre-Certification 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	Deductible, then 60% of allowed amount	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	
	Childbirth/delivery facility services	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	
If you need help recovering or have other special health needs	Home health care	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	Limited to 60 visits/benefit plan year
	Rehabilitation services	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	Limited to 40 visits for Physical Therapy and 20 visits for occupational and Speech therapy plan year.
	Habilitation services	No Benefit	No Benefit	Per Plan Provisions
	Skilled nursing care	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	*Pre-Certification Required. Failure to obtain prior authorization may result in a penalty of $200 or denial of benefits.
	Durable medical equipment	Deductible, then 30% coinsurance	Deductible, then 50% of allowed amount	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	Deductible, then 30% coinsurance	Deductible, then 50% 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

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)	
	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, or the U.S. Department of Health and Human Services at 1-877-267-2323, extension 61565 or 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 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, kwiijigo 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	30%
Other coinsurance	30%

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	$12,435

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$340
Coinsurance	$1091
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2092

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	30%
Other coinsurance	30%

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	$7,389

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$600
Copayments	$700
Coinsurance	$878
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2233

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	30%
Other coinsurance	30%

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	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$600
Copayments	$0
Coinsurance	$410
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1010

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.

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