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, www.liveandworkwell.com or by calling 1-866-248-4098. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-248-4098 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**N/A**	Not applicable
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?	**N/A**	This plan does not have an out-of-pocket limit on expenses.
What is not included in the out-of-pocket limit?	**N/A**	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. For a list of providers see www.liveandworkwell.com or call 1-866-248-4098 providers.	This plan covers only in-network providers. If you use an in-network health care provider, this plan will pay some of all the costs of covered services as described on the following chart.
Do you need a referral to see a specialist?	**N/A**	Not applicable

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	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Specialist visit	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Preventive care/screening/ immunization	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
If you have a test	Diagnostic test (x-ray, blood work)	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Imaging (CT/PET scans, MRIs)	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthcomp.com	Generic drugs	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Preferred brand drugs	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Non-preferred brand drugs	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Specialty drugs	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Physician/surgeon fees	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
If you need immediate medical attention	Emergency room care	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Emergency medical transportation	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Urgent care	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
If you have a hospital stay	Facility fee (e.g., hospital room)	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.

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	Physician/surgeon fees	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No coverage	This plan covers up to 6 sessions per year.
	Inpatient services	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
If you are pregnant	Office visits	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Childbirth/delivery professional services	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Childbirth/delivery facility services	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
If you need help recovering or have other special health needs	Home health care	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Rehabilitation services	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Habilitation services	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Skilled nursing care	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Durable medical equipment	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Hospice services	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
If your child needs dental or eye care	Children's eye exam	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Children's glasses	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.
	Children's dental check-up	No coverage	No coverage	This plan doesn't provide any coverage for this type of service.

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
- Chiropractic Care
- Cosmetic Surgery
- Dentals Care (Adult)
- 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 Program

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

- None

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: contact the plan at 1-866-248-4098. You may also contact your state insurance department, the 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 x61565 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 on how 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:
Optum Appeals Department
P.O. Box 30512
Salt Lake City, UT 94130-0512

You may also contact Optum at 866-248-4098.

www.liveandworkwell.com

Does this plan provide Minimum Essential Coverage? **No**
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? **No**
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 1-866-248-4098

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	**$0**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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

The plan's overall deductible	**$0**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

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

The plan's overall deductible	**$0**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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

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