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 1-866-871-0964. 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.SWSCHP.org or call 1-866-871-0964 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0 Out-of-Network (and in-network non-emergency services): $1,000 Individual/ $3,000 Family	In-Network: See the Common Medical Events chart below for your costs for services this plan covers. Out-of-Network: 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?	In-Network: Not applicable. Out-of-Network: Yes. prescription drugs, emergency room care, emergency medical transportation, inpatient hospital facilities, some outpatient hospital, hospice services and home health care are covered before you meet your deductible.	In-Network: This plan does not have an in-network deductible; however, non-emergent visits to hospital ER are subject to the out of network deductible and coinsurance. Out-of-Network: 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?	In-Network Medical: $2,000 Individual/$4,000 Family. Out-of-Network Medical: $3,250 Individual/$9,500 Family. Prescription drugs: $3,600 Individual/$7,200 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?	In-Network and Out-of-Network: premiums, balance billing, penalties for failure to obtain preauthorization for services, and health care this plan does not cover. Out-of-Network also excludes copayments (except for emergency services) and deductibles.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see www.SWSCHP.org or call 1-866-871-0964.	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	$25 copay/visit	30% coinsurance plus balance billing	Applies to family practitioner, internist, general practitioner, pediatrician and OB/GYN physicians.
	Specialist visit	$25 copay/visit	30% coinsurance plus balance billing	Pre-certification required for procedures listed in your SPD.
	Preventive care/screening/ immunization	No charge	30% coinsurance plus balance billing	Subject to age and frequency limits. 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. Out-of-Network. As with all claims for out-of-network providers, you are responsible for any amounts over the Plan's Allowed Amount and out-of-network providers may balance bill you for these amounts.

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 test	Diagnostic test (x-ray, blood work)	Quest Labs: No charge Outpatient hospital: $50 copay/visit Independent free-standing facilities: $30 copay/visit	Outpatient hospital: $50 copay/visit All other facilities/professional fees: 30% coinsurance plus balance billing	No charge for preadmission testing within 14 days of hospital admission at outpatient hospital facility. Quest Labs does not perform certain tests such as fertility, bone marrow, or spinal fluids.
	Imaging (CT/PET scans, MRIs)	US Imaging provider: No charge Independent free standing facilities: $75 copay/visit Outpatient hospital: $75 copay/visit	Outpatient hospital: $75 copay/visit All other facilities/professional fees: 30% coinsurance plus balance billing	Pre-certification required. Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.Caremark.com**	Generic drugs	Short-term drugs (Retail): $7.50 copay/script (after initial and 1 refill, $15 copay/script) Long-term drugs (Retail and mail order): $15 copay/script	You pay 100% of the retail cost and then you may file a claim for reimbursement	Out-of-network deductible does not apply. Retail - up to 30-day supply; Mail Order - up to 90-day supply. No charge for generic contraceptives (or brand-name contraceptive if generic is medically inappropriate) and other Affordable Care Act (ACA) required prescriptions received from a participating pharmacy with a prescription. For non-participating pharmacies, you must submit a claim and pay the difference in the cost of the drug at a participating pharmacy and the cost at a non-participating pharmacy in addition to the copay. You are also responsible for difference in cost between brand and generic drugs where generic equivalent is available. Some drugs may be subject to preauthorization. Step-therapy or other drug utilization management may apply. After one initial fill plus one refill at a retail pharmacy, you will be responsible for a Copay that is double the usual Copay for short-term drugs.
	Preferred brand drugs	Short-term drugs (Retail): $30 copay/script (after initial and 1 refill, $60 copay/script) Long-term drugs (Retail and mail order): $ 60 copay/script	You pay 100% of the retail cost and then you may file a claim for reimbursement	
	Non-preferred brand drugs	Short-term drugs (Retail): $50 copay/script (after initial and 1 refill, $100 copay/script) Long-term drugs (Retail and mail order): $100 copay/script	You pay 100% of the retail cost and then you may file a claim for reimbursement	
	Specialty drugs	CVS Specialty Pharmacy only: 30-day supply: $16.67 copay/script	Not covered	With limited exceptions, specialty drugs are only available through the CVS Specialty Pharmacy and require preauthorization.

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)	
		No charge for certain non-essential specialty drugs on the PrudentRx Specialty Drug List if you enroll in the program. You pay 30% coinsurance on the cost of these non-essential specialty drugs if you do not enroll in the program.		Your cost sharing for certain non-essential specialty drugs, as well as any amount paid by the drug manufacturer through its copay assistance program, do not count toward your out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Freestanding facility: No charge Outpatient hospital: $75 copay/procedure	Freestanding facility: 30% coinsurance plus deductible Outpatient hospital: $75 copay/procedure	Pre-certification required, except office setting. Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify.
	Physician/surgeon fees	$25 copay/visit	30% coinsurance plus balance billing	For more information about limitations and exceptions, see the SPD.
If you need immediate medical attention	Emergency room care	Emergency room: $75 copay/visit Per provider: $25 copay/visit	Emergency room: $75 copay/visit Per provider: $25 copay/visit; deductible does not apply	Copay waived if admitted. Providers may be Out-of-Network even when ER is In-Network and may bill separately. Treatment received in emergency room that is classified as non-emergent care or not considered Emergency Services for an Emergency Medical Condition subject to out-of-network deductible, coinsurance and balance billing.
	Emergency medical transportation	$50 copay/trip	$50 copay/trip; deductible does not apply	Only includes transfers between facilities if medically necessary; separate charges for paramedic intercept not covered. Air ambulance covered based on medical review.
	Urgent care	$25 copay/visit	30% coinsurance	Includes hospital urgent care and free-standing clinics.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admission	$200 copay/admission; deductible does not apply	Pre-certification required. Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify. Separate copay applies if admitted to new facility. After 365 days per Spell of Illness, you pay 30% coinsurance at both In-Network and Out-
	Physician/surgeon fees	$25 copay/visit	30% coinsurance plus balance billing	

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)	
				of-Network facilities. For more information about limitations and exceptions, see the SPD.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and professional services: $25 copay/visit Outpatient hospital/facility: $30 copay/visit	30% coinsurance plus balance billing	No cost sharing for In-Network testing. Family counseling limited to 20 visits per Plan Year.
	Inpatient services	$200 copay/admission	$200 copay/admission; deductible does not apply	Pre-certification required. Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify. After 365 days, both In-Network and Out-of-Network facilities subject to 30% coinsurance. For residential stay approval, it must meet medical criteria and facility must be accredited by The Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF) or no benefits are payable. Out-of-Network facility must also be state approved.
If you are pregnant	Office visits	No charge	30% coinsurance; plus balance billing	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). No charge for In-network preventive services. Depending on type of services and provider, a copayment, coinsurance or deductible may apply. Notice should be given to Medical Management Program within 30 days of expected delivery.
	Childbirth/delivery professional services	$25 copay/visit	30% coinsurance; plus balance billing	
	Childbirth/delivery facility services	$200 copay/admission	$200 copay/admission; deductible does not apply	
If you need help recovering or have other special health needs	Home health care	No charge up to allowed amount	No charge up to allowed amount; deductible does not apply	Pre-certification required. Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify. Coverage for 365 days per spell of illness. 3 visits equals 1 benefit day. Visiting nurse services may not be received at same time as home health care.

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)	
	Rehabilitation services	Outpatient professional visits: $25 copay/visit; Outpatient facility: $30 copay/visit Inpatient facility: $200 copay/admission	Outpatient visits: 30% coinsurance plus deductible plus balance billing; Outpatient facility: $30 copay Inpatient facility: $200 copay/admission; deductible does not apply	Pre-certification required. Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify.
	Habilitation services	Outpatient professional visits: $25 copay/visit; Outpatient facility: $30 copay/visit Inpatient facility: $200 copay/admission	Outpatient visits: 30% coinsurance plus deductible plus balance billing; Outpatient facility: $30 copay Inpatient facility: $200 copay/admission; deductible does not apply	Pre-certification required. Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify.
	Skilled nursing care	Outpatient visit: Visiting nurse services: $25 copay/visit Inpatient facility: No charge up to allowed amount	Outpatient visit: 30% coinsurance plus balance billing; Inpatient facility: No charge; deductible does not apply	Pre-certification required. Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify. Coverage for 365 benefit days per spell of illness, 2 days SNF equals 1 benefit day. Visiting nurse services may not be received at same time as home health care.
	Durable medical equipment	No charge up to allowed amount	30% coinsurance plus balance billing	Pre-certification required for rentals/purchase over $500. Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify.
	Hospice services	No charge up to allowed amount	No charge up to allowed amount; deductible does not apply	Pre-certification required. Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of these expenses, even In-Network.
	Children's glasses			
	Children's dental check-up			

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 (unless required for reconstructive surgery which is incidental to or follows surgery or reconstructive surgery due to a congenital disease or anomaly which has resulted in a functional defect to a Dependent Child)
- Dental care (Adult and Child) (except dental or oral surgical procedures due to accidental injury or congenital disorders)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Child) (except following cataract surgery)
- Routine foot care
- Weight loss programs (except as required under ACA preventive benefit)

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

- Acupuncture
- Bariatric surgery (if medically necessary)
- Chiropractic care
- Hearing aids ($600 max once every 36 months)
- Infertility treatment (Artificial reproduction requires pre-certification and is limited to 4 attempts per lifetime)
- Private-duty nursing (Pre-certification required. Outpatient only, maximum payment of $30/hr for participating and non-participating providers)

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: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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: Member services at (866) 871-0964 or visit www.swschp.org. You may also contact the New York State Department of Financial Services, One Commerce Plaza, Albany, NY 12257, 800-342-3736 or visit: http://www.dfs.ny.gov. Additionally, a consumer assistance program can help you file your appeal or answer questions about "Surprise Bills". Contact: Consumer Assistance Unit, New York State Department of Financial Services, One Commerce Plaza, Albany, NY 12257, 800-342-3736, www.dfs.ny.gov/consumer/fileacomplaint.htm.

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(888) 779-7247.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1(888) 779-7247.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1(888) 779-7247.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1(888) 779-7247.

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 copay	**$25**
Hospital (facility) copay	**$200**
Other copay (blood work)	**$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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$520
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$580**

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 copay	**$25**
Hospital (facility) copay	**$200**
Other copay (blood work)	**$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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,200**

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

The plan's overall deductible	**$0**
Specialist copay	**$25**
Hospital (facility) copay	**$200**
Other copay (ER)	**$75**

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	$530
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$530**

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