**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 1-866-375-0775 or visit us at www.helpwithmyplan.com. 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.cciio.cms.gov or call 1-866-375-0775 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?** | **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. 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 don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **Not Applicable** | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | **Not Applicable** | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | **Not Applicable** | This plan does not use a provider network. You can receive covered services from any provider. |
| **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 |
|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Specialist visit | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Preventive care/screening/ immunization | $0 | Plan limited to recommended preventive care only. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| **If you have a test** | Diagnostic test (x-ray, blood work) | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Imaging (CT/PET scans, MRIs) | Not Covered | Not Covered – Plan limited to preventive care only. |
| | HIV Screening | $0 | Plan limited to recommended preventive care only. |
| | Colorectal Cancer Screening for Adults over 50. | $0 | Plan limited to recommended preventive care only. |
| **If you need contraceptive drugs**<br>More information about **prescription drug coverage** is available by calling 1-866-375-0775 | Generic Contraceptive drugs | $0 Contraceptives only | Plan limited to recommended preventive care only. |
| | Brand Name Contraceptive drugs | $50 Contraceptives only | Plan limited to recommended preventive care only. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Physician/surgeon fees | Not Covered | Not Covered – Plan limited to preventive care only. |
| **If you need immediate medical attention** | Emergency room care | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Emergency medical transportation | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Urgent care | Not Covered | Not Covered – Plan limited to preventive care only. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Physician/surgeon fees | Not Covered | Not Covered – Plan limited to preventive care only. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Inpatient services | Not Covered | Not Covered – Plan limited to preventive care only. |
| **If you are pregnant** | Anemia screening on a routine basis for pregnant women | $0 | Plan limited to recommended preventive care only. |
| | Childbirth/delivery professional services | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Childbirth/delivery facility services | Not Covered | Not Covered – Plan limited to preventive care only. |
| **If you need help recovering or have other special health needs** | Home health care | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Rehabilitation services | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Habilitation services | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Skilled nursing care | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Durable medical equipment | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Hospice services | Not Covered | Not Covered – Plan limited to preventive care only. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| **If your child needs dental or eye care** | Children's eye exam | $0 | Plan limited to recommended preventive care only. |
| | Children's glasses | Not Covered | Not Covered – Plan limited to preventive care only. |
| | Children's dental check-up | Not Covered | Not Covered – Plan limited to preventive care only. |

## 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.)**

- preventive health services not meeting the requirements of the Affordable Care Act;
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental 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, and
- Weight loss programs

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

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**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/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 1-800-318-2596.

**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:

RSL Specialty Products Administration
Toll-Free - 1-866-375-0775
Written appeals should be mailed to:
RSL Specialty Products Administration
Claims Department
505 S. Lenola Road, Suite 231
Moorestown, NJ 08057

Department of Labor's Employees Benefit Security Administration, Toll Free - 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform.

ERISA Plan Administrator:
Connie Cafone
973-695-0949
By mail to:
25 Washington Street
Morristown, NJ 07960

**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 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.

*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 | 100% |

**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** | **$12,870** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Peg would pay is** | **$12,600** |

### 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 | 100% |

**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** | **$7,660** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Joe would pay is** | **$7,050** |

### 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 | 100% |

**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** | **$2,020** |

**In this example, Mia would pay (This condition is not covered so patient pays 100 percent):**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Mia would pay is** | **$2,020** |

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