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 800-948-5988. 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.dol.gov/ebsa/healthreform or call 800-948-5988 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: **$1,500**/individual, **$1,500**/individual under family or **$3,000**/family Out-of-network provider: **$4,500**/individual, **$4,500**/individual under family or **$9,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. The deductible is **Embedded**. 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. **Deductible year runs 01/01 – 12/31**
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 care 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?	Network providers: **$4,500**/individual, **$4,500**/individual under family or **$9,000**/family Out-of-network providers: **$13,500**/individual, **$13,500**/individual under family or **$27,00**/family	The out-of-pocket limit is the most you could pay in a year for covered services. The out-of-pocket limit is **Embedded**. 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.RevoHealthBenefits.com or call 800-948-5988 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).

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	$35 copayment	40% coinsurance	Deductible does not apply to copayment.
	Specialist visit	$35 copayment	40% coinsurance	Deductible does not apply to copayment.
	Preventive care/screening/ immunization	No charge	40% coinsurance	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. For Out-of-Network Preventive care, there is a $1,000 maximum per plan participant.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Diagnostic tests associated with office visits are covered at No Charge.
	Imaging (CT/PET scans, MRIs)	Free Standing: 20% coinsurance Hospital Based: 40% coinsurance	Free Standing: 40% coinsurance Hospital Based: 50% coinsurance	May require preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.RevoHealthBenefits.com	Generic drugs	30-day supply Retail: $20 copayment/Prescription 90-day supply Mail Order: $40 copayment/Prescription		Cost sharing does not apply for preventive Prescriptions. Deductible does not apply to copayment. Retail & Mail Order available up to a 90-day supply.
	Preferred brand drugs	30-day supply Retail: $80 copayment/Prescription 90-day supply Mail Order: $160 copayment/Prescription		
	Non-preferred brand drugs	30-day supply Retail: $150 copayment/Prescription 90-day supply Mail Order: $300 copayment/Prescription		
	Specialty drugs	30-day supply Mail Order: 30% coinsurance		Deductible does not apply to coinsurance. Mail Order available up to a 30-day supply.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Free Standing: 20% coinsurance	Free Standing: 40% coinsurance	May require preauthorization.
	Physician/surgeon fees	Hospital Based: 40% coinsurance	Hospital Based: 50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	40% coinsurance	True emergency covered at in-network level.
	Emergency medical transportation	20% coinsurance	40% coinsurance	True emergency covered at in-network level.
	Urgent care	$65 copayment	40% coinsurance	Deductible does not apply to copayment.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copayment	40% coinsurance	Deductible does not apply to copayment.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required.
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization required.
	Rehabilitation services	$35 copayment	40% coinsurance	$500 maximum combined benefit per year when treatment is with an out-of-network provider.
	Habilitation services	$35 copayment	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization required.
	Durable medical equipment	20% coinsurance	40% coinsurance	None.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	One per year. Out of Network eye exams are reimbursed at 90% of the maximum allowable charge.
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	None.

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
- Weight loss programs
- Dental Care (Adult)
- Hearing Aids
- Bariatric Surgery
- Acupuncture
- Long-term care
- Non-emergency care when traveling outside the U.S.

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

- Infertility Treatment (correction of physiological abnormalities)
- Routine Eye Care (one exam/year)
- Routine Foot Care
- Emergency care when traveling outside the U.S.
- Chiropractic Care
- Private Duty Nursing (inpatient only)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (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: : Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 800-948-5988
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-948-5988
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 800-948-5988
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-948-5988

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.RevoHealthBenefits.com.

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	$1,500
Specialist *Copayment*	$35
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic test (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,770**

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

The plan's overall deductible	$1,500
Specialist *Copayment*	$35
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic test *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,420**

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

The plan's overall deductible	$1,500
Specialist *Copayment*	$35
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	20%

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	$1,500
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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