




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.MyPOMCO.com](http://www.MyPOMCO.com) or 1-866-227-9936. 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 1-866-227-9936 to request a copy. Includes through amendment 2015-003.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	You will have to meet the <a href="#">deductible</a> before the plan pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	Yes. <b>Outpatient services:</b> <a href="#">network providers</a> \$183 individual, \$366 two persons, \$549 family. <a href="#">out-of-network provider</a> : \$1,000 individual/ \$3,000 family. Does not apply to benefits paid at 100%.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">network providers</a> \$2,250/individual + <a href="#">deductible</a> , \$3,500/family + <a href="#">deductible</a> ; <a href="#">out-of-network providers</a> \$2,500/individual + <a href="#">deductible</a> / \$5,000/family + <a href="#">deductible</a> . Prescription drugs: \$2,820/individual, \$4,650/ family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Ancillary & extended benefits, infertility, refractive surgery, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.MyPOMCO.com">www.MyPOMCO.com</a> or call 1-866-227-9936 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: \$25 <a href="#">copay</a> . Blood work: no charge	30% <a href="#">coinsurance</a>	<a href="#">network</a> X-ray in excess of \$2,500: \$100 <a href="#">copay</a>
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copay</a>	30% <a href="#">coinsurance</a>	Precertify or up to \$250 penalty. <a href="#">copay/deductible</a> waived if services performed at US Imaging.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ProActrx.com">www.ProActrx.com</a>	Generic drugs	<a href="#">copay</a> /prescription: \$10 (retail) \$20 (mail order)		Covers up to a 31-day supply (retail prescription); 32-93 day supply (mail order prescription).
	Preferred brand drugs	<a href="#">copay</a> /prescription: \$35 (retail) \$70 (mail order)		
	Non-preferred brand drugs	<a href="#">copay</a> /prescription: \$70 (retail) \$140 (mail order)		
	<a href="#">Specialty drugs</a>	<a href="#">copay</a> /prescription: \$50 (retail) \$100 (mail order)		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	30% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	Surgery under \$500: no charge	30% <a href="#">coinsurance</a>	<a href="#">network</a> surgery over \$500: \$250 <a href="#">copay</a> . Certain surgeries require precertification.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a>		None
	<a href="#">Emergency medical transportation</a>	No charge		\$500 <a href="#">copay</a> for air ambulance. See plan document for more details.
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$500 <a href="#">copay</a> /visit	\$500 <a href="#">copay</a> /visit then 30% <a href="#">coinsurance</a>	Precertify or up to \$250 reduction.
	Physician/surgeon fees	\$25 <a href="#">copay</a> (physician), \$250 <a href="#">copay</a> (surgeon)	30% <a href="#">coinsurance</a>	Precertify certain surgeries. Surgeries under \$500 no <a href="#">network copays</a> .

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	None
	Inpatient services	\$500 <a href="#">copay</a>	30% <a href="#">coinsurance</a>	Precertify or up to \$250 reduction.
<b>If you are pregnant</b>	Office visits	\$25 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	See plan document for Healthy Beginnings program details. <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	\$250 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$500 <a href="#">copay</a>	30% <a href="#">coinsurance</a>	Depending on the type of services, <a href="#">copay</a> or <a href="#">coinsurance</a> may apply
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$25 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	Precertify or up to \$250 reduction. 200 visits/calendar year, plus an additional 50 visits/lifetime if medically necessary.
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	30 visits/year, plus an additional 20 visits if medically necessary. Includes physical speech, and occupational therapies.
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing care</a>	\$500 <a href="#">copay</a>	\$500 <a href="#">copay</a> then 30% <a href="#">coinsurance</a>	Precertify or up to \$250 reduction. 100 days/calendar year, plus an additional 60 days for <a href="#">network providers</a> if medically necessary.
	<a href="#">Durable medical equipment</a>	No charge	30% <a href="#">coinsurance</a>	Precertify equipment exceeding \$500 or up to \$250 reduction. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	No charge	30% <a href="#">coinsurance</a>	Precertify or up to \$250 reduction. 210 days/lifetime.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$25 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	None
	Children's glasses	Not covered		None
	Children's dental check-up	Not covered		Separate plan offered.

### 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
- Long Term Care
- Routine Foot Care

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

- Acupuncture
- Bariatric Surgery (program enrollment required)
- Chiropractic Care
- Hearing Aids
- Infertility Treatment (program enrollment required)
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine Eye Care
- Weight Loss Programs

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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: POMCO, 2425 James Street, Syracuse, New York 13206, 1-866-227-9936, [www.MyPOMCO.com](http://www.MyPOMCO.com).

**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? 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](#).

—————*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](#) \$183
- [Specialist](#) \$25
- Hospital (facility) 10%
- Other 10%

**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*)

<b>Total Example Cost</b>	<b>\$12978</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$148
Copayments	\$845
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1053</b>

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

- The [plan's](#) overall [deductible](#) \$183
- [Specialist](#) \$25
- Hospital (facility) 10%
- Other 10%

**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*)

<b>Total Example Cost</b>	<b>\$7400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$183
Copayments	\$1015
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1253</b>

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

- The [plan's](#) overall [deductible](#) \$183
- [Specialist](#) \$25
- Hospital (facility) 10%
- Other 10%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1925</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$183
Copayments	\$175
Coinsurance	\$33
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$391</b>

□