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 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 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?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. **Outpatient services:** network providers $183 individual, $366 two persons, $549 family. out-of-network provider: $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 deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	network providers $2,250/individual + deductible, $3,500/family + deductible; out-of-network providers $2,500/individual + deductible/ $5,000/family + deductible. Prescription drugs: $2,820/individual, $4,650/ 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?	Ancillary & extended benefits, infertility, refractive surgery, 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.MyPOMCO.com or call 1-866-227-9936 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). 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	None
	Specialist visit	$25 copay/visit	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $25 copay. Blood work: no charge	30% coinsurance	network X-ray in excess of $2,500: $100 copay
	Imaging (CT/PET scans, MRIs)	$100 copay	30% coinsurance	Precertify or up to $250 penalty. copay/ deductible waived if services performed at US Imaging.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ProActrx.com	Generic drugs	copay/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	copay/prescription: $35 (retail) $70 (mail order)		
	Non-preferred brand drugs	copay/prescription: $70 (retail) $140 (mail order)		
	Specialty drugs	copay/prescription: $50 (retail) $100 (mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	None
	Physician/surgeon fees	Surgery under $500: no charge	30% coinsurance	network surgery over $500: $250 copay. Certain surgeries require precertification.
If you need immediate medical attention	Emergency room care	$100 copay		None
	Emergency medical transportation	No charge		$500 copay for air ambulance. See plan document for more details.
	Urgent care	$25 copay/visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/visit	$500 copay/visit then 30% coinsurance	Precertify or up to $250 reduction.
	Physician/surgeon fees	$25 copay (physician), $250 copay (surgeon)	30% coinsurance	Precertify certain surgeries. Surgeries under $500 no network copays.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	30% coinsurance	None
	Inpatient services	$500 copay	30% coinsurance	Precertify or up to $250 reduction.
If you are pregnant	Office visits	$25 copay/visit	30% coinsurance	See plan document for Healthy Beginnings program details. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$250 copay/visit	30% coinsurance	
	Childbirth/delivery facility services	$500 copay	30% coinsurance	Depending on the type of services, copay or coinsurance may apply
If you need help recovering or have other special health needs	Home health care	$25 copay/visit	30% coinsurance	Precertify or up to $250 reduction. 200 visits/ calendar year, plus an additional 50 visits/ lifetime if medically necessary.
	Rehabilitation services	$25 copay/visit	30% coinsurance	30 visits/year, plus an additional 20 visits if medically necessary. Includes physical speech, and occupational therapies.
	Habilitation services			
	Skilled nursing care	$500 copay	$500 copay then 30% coinsurance	Precertify or up to $250 reduction. 100 days/ calendar year, plus an additional 60 days for network providers if medically necessary.
	Durable medical equipment	No charge	30% coinsurance	Precertify equipment exceeding $500 or up to $250 reduction. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	30% coinsurance	Precertify or up to $250 reduction. 210 days/ lifetime.
If your child needs dental or eye care	Children's eye exam	$25 copay/visit	30% coinsurance	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) • Chiropratic 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. 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: POMCO, 2425 James Street, Syracuse, New York 13206, 1-866-227-9936, 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)*

Total Example Cost	**$12978**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$148
Copayments	$845
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1053**

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)*

Total Example Cost	**$7400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$183
Copayments	$1015
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1253**

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)*

Total Example Cost	**$1925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$183
Copayments	$175
Coinsurance	$33
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$391**

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