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, contact Shasta Administrative Serivces at 1-800-441-4518, or by email at question@shastatpa.com. For 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.shastatpa.com or call 1-800-441-4518 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 individual / $4,000 family for participating providers. $2,000 individual / Unlimited family for non-participating providers.	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 policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes. Preventive care services that are obtained by an in-network provider.	This plan covers some items and services even if you haven't met the annual 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 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?	$5,000 individual / $10,000 family for participating providers. $1,600 individual / $3,200 family for participating pharmacies. Unlimited for non-participating providers and pharmacies.	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?	Premiums, balance-billed charges, pre-authorization penalties, out of network 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.shastatpa.com or call (800) 441-4518 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 (a balance bill).
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	$30 copay/visit	$30 copay/visit 50% coinsurance	Deductible Waived
	Specialist visit	$30 copay/visit	$30 copay/visit 50% coinsurance	Deductible Waived
	Preventive care/screening/ immunization	No Charge	50% coinsurance	Deductible Waived
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% coinsurance	Deductible Waived. Pre-authorization is required for 3D maternity ultrasounds.
	Imaging (CT/PET scans, MRIs)	No Charge	50% coinsurance	Deductible Waived. Pre-authorization is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	Retail: $10 copay Mail: $20 copay	Not Covered	Retail: 31-day supply prescription Mail: 90-day supply prescription
	Preferred brand drugs	Retail: $25 copay Mail: $50 copay	Not Covered	Retail: 31-day supply prescription Mail: 90-day supply prescription
	Non-preferred brand drugs	Retail: $40 copay Mail: $120 copay	Not Covered	Retail: 31-day supply prescription Mail: 90-day supply prescription
	Specialty drugs	Same as applicable copays listed for generics, brand/preferred brands, and brands/non-preferred brands drugs. Copay does not apply if dual covered.	Not Covered	Up to a 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Pre-authorization is required
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Pre-authorization is required
If you need immediate medical attention	Emergency room care	$100 copay/visit 30% coinsurance	$100 copay/visit 30% coinsurance	Non-emergency services are a plan exclusion.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Non-emergency services are a plan exclusion.
	Urgent care	$30 copay/visit	$30 copay/visit 50% coinsurance	Deductible Waived

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

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 hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Pre-authorization is required
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Pre-authorization is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	$30 copay/visit 50% coinsurance	Deductible Waived
	Inpatient services	0% coinsurance	50% coinsurance	Pre-authorization is required
If you are pregnant	Office visits	$30 copay/visit	$30 copay/visit 50% coinsurance	Dependent children are not covered for maternity services. Deductible Waived.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	Dependent children are not covered for maternity services.
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Dependent children are not covered for maternity services.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Pre-authorization is required. Limited to 130 visits per calendar year.
	Rehabilitation services	30% coinsurance	50% coinsurance	Pre-authorization is required if inpatient.
	Habilitation services	30% coinsurance	50% coinsurance	Pre-authorization is required if inpatient.
	Skilled nursing care	No Charge	50% coinsurance	Pre-authorization is required. Deductible Waived.
	Durable medical equipment	30% coinsurance	50% coinsurance	Pre-authorization is required if over $2,500, wheelchairs if over $5,000, or any cost if for electric hospital beds, ventilators, continuous passive motion devices, bone growth stimulation, tens unit, insulin pumps, CPAP, and prosthetics.
	Hospice services	30% coinsurance	50% coinsurance	Pre-authorization is required. Limited to 6 months maximum.
If your child needs dental or eye care	Children's eye exam	Vision benefits are administered by Ameritas. Please contact Ameritas at (800) 487-5553.		
	Children's glasses	Vision benefits are administered by Ameritas.. Please contact Ameritas at (800) 487-5553.		
	Children's dental check-up	Dental benefits are administered by Ameritas. Please contact Ameritas at (800) 487-5553.		

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

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.)		
• Bariatric surgery • Cosmetic surgery • Dental care • Glasses	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the United States	• Private-duty nursing • Routine foot care • Weight loss programs

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

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 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: 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) 441 - 4518.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [(800) 441 - 4518.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [(800) 441 - 4518.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [(800) 441 - 4518.]

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.shastatpa.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	$2,000
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	0%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$30
Coinsurance	$3,231
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$5,261

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

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	0%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$30
Coinsurance	$1,611
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$3,641

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

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$75
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	0%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,825
Copayments	$75
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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