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 see www.lucenthealth.com/capitol or call 1-800-331-5301. 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 1-800-331-5301 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: **$250** individual / **$500** family Out-of-network providers: **$1,600** individual / **$3,200** family	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 plan, the family deductible does not need to be met before this plan begins to pay for an individual member.
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care services, and prescription drugs 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 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?	Network providers: **$3,250** individual / **$6,500** family Out-of-network providers: **$9,500** individual / **$19,000** 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?	Premiums, balance-billed charges, penalties for non-compliance, and health care this plan does not 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.hstcareconnect.com/advocate or call 800-331-5301 for a list of PPO providers**.** **Facility/Hospital** services are reimbursed under the VBP guidelines.	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 permission from this plan.

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/office visit, deductible does not apply	50% coinsurance	None
	Specialist visit	$50 copay/office visit, deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No charge, deductible does not apply	No charge, deductible does not apply	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Facility services are reimbursed under the VBP guidelines of the plan and are subject to the PPO deductible and coinsurance.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cvscaremark.com 1-800-824-6349	Generic drugs	Retail (30-day supply): $10 copay/prescription Retail (90-day supply): $25 copay/prescription Mail Order (90-day supply): $20 copay/prescription	Not Covered	Deductible does not apply. Covers up to a 90-day supply (retail and mail order prescription). Prescription Drugs recommended by the HRSA or USPSTF will be covered at 100% as required by ACA.
	Preferred brand drugs	Retail (30-day supply): $30 copay/prescription Retail (90-day supply): $75 copay/prescription Mail Order (90-day supply): $60 copay/prescription		
	Non-preferred brand drugs	Retail (30-day supply): $75 copay/prescription Retail (90-day supply): $188 copay/prescription Mail Order (90-day supply): $150 copay/prescription		

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

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)	
	Specialty drugs	25% coinsurance up to a $175 maximum	Not Covered	Specialty drugs are limited to a 30-day supply.
	Members pay $0 out-of-pocket (OOP) for all specialty medications on the client's Exclusive Specialty drug list dispensed by CVS Specialty. Covers up to a 30-day supply. Contact CVS/Caremark, your specialty prescription drug vendor for applicable costs.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/visit; deductible does not apply	50% coinsurance	Prior Authorization is required. Facility services are reimbursed under the VBP guidelines of the plan and are subject to the PPO deductible and coinsurance.
	Physician/surgeon fees	No charge-based on Advocate VBP amount	50% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay/visit; deductible does not apply		Facility services are reimbursed under the VBP guidelines of the plan and are subject to the PPO deductible and coinsurance.
	Emergency medical transportation	20% coinsurance		Non-emergent ambulance services are not covered.
	Urgent care	$50 copay/office visit; deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/visit; deductible does not apply	50% coinsurance	Prior Authorization is required. Facility services are reimbursed under the VBP guidelines of the plan and are subject to the PPO deductible and coinsurance.
	Physician/surgeon fees	No charge-based on Advocate VBP amount	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Prior Authorization is required for inpatient services. Facility services are reimbursed under the VBP guidelines of the plan and are subject to the PPO deductible and coinsurance.
	Inpatient services	$200 copay; deductible does not apply	50% coinsurance	
	Office Visit	$25 copay/office visit; deductible does not apply	50% coinsurance	

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

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 are pregnant	Office visits	$25 copay/office visit; deductible does not apply	50% coinsurance	Cost Sharing does not apply to preventative services. Depending on the type of service, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for vaginal deliveries requiring more than a 48 hour stay and cesarean section deliveries requiring more than a 96 hour stay to avoid penalty.
	Childbirth/delivery professional services	No charge-based on Advocate VBP amount	50% coinsurance	
	Childbirth/delivery facility services	$200 copay; deductible does not apply	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Prior Authorization is required. Limited to 130 visits per Calendar Year.
	Rehabilitation services	20% coinsurance	50% coinsurance	Limited to 30 days per Calendar Year, with an additional 30 days per Calendar Year for treatment of spinal cord or head injuries, or for the treatment of cerebral vascular accident.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	$200 copay; deductible does not apply	50% coinsurance	Prior Authorization is required. Limited to 60 visits per Calendar Year.
	Durable medical equipment	20% coinsurance	50% coinsurance	Prior Authorization is required if over $2,000
	Hospice services	20% coinsurance	50% coinsurance	Facility services are reimbursed under the VBP guidelines of the plan. Prior Authorization is required for inpatient services. Limited to 360 days lifetime maximum. Respite care limited to 240 hours.
	Hospice services - facility	$200 copay; deductible does not apply		

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

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 your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.

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 (adult)
- Hearing Aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- 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 (Limited to 12 visits per Calendar Year)
- Chiropractic Care (Limited to 24 visits per Calendar Year

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. 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 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: the plan at voestalpine Group Health Plan c/o Lucent Health Solutions, LLC at PO Box 7020 Appleton, WI 54912-7020 or call 1-800-331-5301. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIO/Resources/Consumer-Assistance-Grants.

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

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 1-800-331-5301.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-331-5301.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-331-5301.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-331-5301.

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** **$250**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$200**
- **Other coinsurance** **20%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$910**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$200**
- **Other coinsurance** **20%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,170**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$50**
- **Hospital (facility) copayment** **$200**
- **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	$250
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950**

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