




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, visit

www.theamericanworker.com or call 1-855-495-1190. 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 1-855-495-1190 to request a copy.

| 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 ? | Yes | 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 ? | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. |
| What is not included in the out-of-pocket limit ? | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. |
| Will you pay less if you use a network provider ? | Yes. See www.multiplan.com/awp or call 1-855-495-1190 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 . NOTE: only preventive services by a specialist are covered. |

 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 | Not Covered | Not Covered | Excluded Service |
| | Specialist visit | Not Covered | Not Covered | Excluded Service |
| | Preventive care/screening/immunization | No Charge | Not Covered | 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. Certain age restrictions may apply. |
| If you have a test | Diagnostic test (x-ray, blood work) | Not Covered | Not Covered | All tests other than preventive care/screening are considered an Excluded Service. |
| | Imaging (CT/PET scans, MRIs) | Not Covered | Not Covered | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling 855-495-1190 | Generic drugs | Not Covered | Not Covered | ACA preventive medications are covered at No Charge. All other medications are offered a discount only. |
| | Preferred brand drugs | Not Covered | Not Covered | |
| | Non-preferred brand drugs | Not Covered | Not Covered | |
| | Specialty drugs | Not Covered | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Not Covered | Not Covered | Excluded Service |
| | Physician/surgeon fees | Not Covered | Not Covered | Excluded Service |
| If you need immediate medical attention | Emergency room care | Not Covered | Not Covered | Excluded Service |
| | Emergency medical transportation | Not Covered | Not Covered | Excluded Service |
| | Urgent care | Not Covered | Not Covered | Excluded Service |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Not Covered | Not Covered | Excluded Service |
| | Physician/surgeon fees | Not Covered | Not Covered | Excluded Service |
| If you need mental | Outpatient services | Not Covered | Not Covered | Excluded Service |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.theamericanworker.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) | |
| health, behavioral health, or substance abuse services | Inpatient services | Not Covered | Not Covered | Excluded Service |
| If you are pregnant | Office visits | Not Covered | Not Covered | <u>Cost sharing</u> does not apply for preventive services. All other services are considered an Excluded Service. |
| | Childbirth/delivery professional services | Not Covered | Not Covered | |
| | Childbirth/delivery facility services | Not Covered | Not Covered | |
| If you need help recovering or have other special health needs | Home health care | Not Covered | Not Covered | Excluded Service |
| | Rehabilitation services | Not Covered | Not Covered | Excluded Service |
| | Habilitation services | Not Covered | Not Covered | Excluded Service |
| | Skilled nursing care | Not Covered | Not Covered | Excluded Service |
| | Durable medical equipment | Not Covered | Not Covered | Excluded Service |
| | Hospice services | Not Covered | Not Covered | Excluded Service |
| If your child needs dental or eye care | Children's eye exam | Not Covered | Not Covered | Excluded Service |
| | Children's glasses | Not Covered | Not Covered | Excluded Service |
| | Children's dental check-up | Not Covered | Not Covered | Excluded Service |

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 .) | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Diagnostic tests (non-preventive) • Eye care (Child) • Home health • Imaging • Maternity • Prescription drugs • Rehabilitation • Skilled nursing care • Weight loss programs | <ul style="list-style-type: none"> • Bariatric surgery • Dental care (Adult) • Durable medical equipment • Habilitation services • Hospice • Infertility treatment • Mental Health services • Primary care visit (non-preventive) • Routine eye care (Adult) • Specialist visit (non-preventive) | <ul style="list-style-type: none"> • Chiropractic care • Dental care (Child) • Emergency services • Hearing aids • Hospital stays • Long-term care • Non-emergency care when traveling outside the U.S • Private-duty nursing • Routine foot care • Surgery |

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

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

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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? No

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 1-855-495-1190.

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

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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](#) \$0
- [Specialist \[cost sharing\]](#) 100%
- Hospital (facility) [\[cost sharing\]](#) 100%
- Other [\[cost sharing\]](#) 100%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|-----------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$12,600 |
| The total Peg would pay is | \$12,600 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) 100%
- Hospital (facility) [\[cost sharing\]](#) 100%
- Other [\[cost sharing\]](#) 100%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$5,400 |
| The total Joe would pay is | \$5,400 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) 100%
- Hospital (facility) [\[cost sharing\]](#) 100%
- Other [\[cost sharing\]](#) 100%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$2,800 |
| The total Mia would pay is | \$2,800 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.