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, call 503-615-3342. 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 www.dol.gov/ebsa/healthreform or call 503-615-3342 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Not Applicable** for One Medical Network. **$1,500** Individual/**$3,000** Family for Preferred, Participating and Out-Of-Network Networks.	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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** ABA therapy, air & ground ambulance, breast pumps, Cologuard, emergency room facility fees, immunizations and flu shots, services with copayment, travel expenses, infertility initial diagnostic testing. Colonoscopies, mammograms, and preventive care for Preferred and Participating Networks. Biofeedback, diagnostic testing, laboratory & x-ray, and office visits for Preferred Network.	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.** There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4,000** Individual/**$8,000** Family for One Medical, Preferred & Participating Networks. **$7,000** Individual/**$14,000** Family for Out-Of-Network. Includes Pharmacy.	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?	Penalties, ineligible charges, premiums, balance-billed 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.accessrga.com or call 1-866-738-3924 for a list of network providers.	You pay the least if you use a provider in the Preferred Network. You pay more if you use a provider in the Participating 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
		One Medical (You will pay the least)	Preferred Provider	Participating or 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	No charge	$25/visit, deductible does not apply	40% coinsurance	————none————
	Specialist visit	No charge	$25/visit, deductible does not apply	40% coinsurance	————none————
	Preventive care/screening/ immunization	No charge	No charge, deductible does not apply	**Participating Network:** No charge, deductible does not apply **Out-of-Network:** 40% coinsurance	Out-of-Network breast pumps, flu shots and immunizations are covered at 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)	No charge	No charge, deductible does not apply	40% coinsurance	————none————
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	40% coinsurance	Preferred and Participating Network Mammograms are covered at no charge, deductible does not apply.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		One Medical (You will pay the least)	Preferred Provider	Participating or Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.optumrx.com	Generic drugs	Not Applicable	$2 copay (Value Generic – retail); $4 copay (Value Generic – retail & mail order); $10 copay (retail); $20 copay (retail & mail order)		Covers up to a 30-day supply (retail prescription); 90-day supply (retail & mail order prescription). See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	Not Applicable	$30 copay (retail); $60 copay (retail & mail order)		
	Non-preferred brand drugs	Not Applicable	$50 copay (retail); $100 copay (retail & mail order)		
	Specialty drugs	Not Applicable	**Generic:** $100 copay; **Preferred brand:** $100 copay; **Non-preferred brand:** 25% coinsurance, deductible does not apply		Please contact OptumRx, your specialty pharmacy, for more information on what is covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	Not Applicable	20% coinsurance	40% coinsurance	————none————
If you need immediate medical attention	Emergency room care	Not Applicable	$200/visit, deductible does not apply		Copay waived if admitted. Emergency room – physician covered at No charge for One Medical and 20% coinsurance for Preferred, Participating & Out-of-Network.
	Emergency medical transportation	Not Applicable	$200/visit, deductible does not apply		————none————
	Urgent care	No charge	$25/visit, deductible does not apply		————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Applicable	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	Not Applicable	20% coinsurance	40% coinsurance	————none————

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		One Medical (You will pay the least)	Preferred Provider	Participating or Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge, deductible does not apply	$25/visit, deductible does not apply	Preauthorization is required for partial hospitalization and intensive outpatient.
	Inpatient services	Not Applicable	20% coinsurance		Preauthorization is required. Residential treatment is covered.
If you are pregnant	Office visits	Not Applicable	No charge, deductible does not apply	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Not Applicable	20% coinsurance	40% coinsurance	————none————
	Childbirth/delivery facility services	Not Applicable	20% coinsurance	40% coinsurance	Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be preauthorized at the time your provider recommends the extended stay.
If you need help recovering or have other special health needs	Home health care	Not Applicable	20% coinsurance	40% coinsurance	Preauthorization is required. Limited to a 140-visit calendar year maximum.
	Rehabilitation services	Not Applicable	**Inpatient:** 20% coinsurance **Outpatient:** $25/visit, deductible does not apply	40% coinsurance	Preauthorization is required for inpatient and is limited to 60-day calendar year maximum. Outpatient is limited to a 60-visit calendar year maximum. Swim therapy is covered.
	Habilitation services	Not Applicable	$25/visit, deductible does not apply	40% coinsurance	Habilitation services, including neurodevelopmental therapy and rehabilitative therapies for the treatment of autism, are covered under the Outpatient Rehabilitation Services benefit. Outpatient Rehabilitation Services visit limits do not apply.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		One Medical (You will pay the least)	Preferred Provider	Participating or Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	Not Applicable	20% coinsurance	40% coinsurance	Preauthorization is required. Limited to a 120-day calendar year maximum.
	Durable medical equipment	Not Applicable	20% coinsurance	40% coinsurance	Preauthorization is required for equipment over $2,000.
	Hospice services	Not Applicable	20% coinsurance	40% coinsurance	Preauthorization is required. Inpatient is limited to a 12-day lifetime maximum. Respite care is limited to a 170-hour maximum every 3 months.
If your child needs dental or eye care	Children's eye exam	Not covered			Please contact vision benefit administrator.
	Children's glasses	Not covered			Please contact vision benefit administrator.
	Children's dental check-up	Not covered			Please contact dental benefit administrator.

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)
- Infertility treatment (except for initial diagnostic testing & office visit)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (except if medically necessary)
- 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 an 18-visit calendar year maximum)
- Chiropractic care (limited to an 18-visit calendar year maximum)
- Hearing aids (limited to 1 hearing aid per ear every 36 months)
- Private-duty nursing (limited to a 120-hour calendar year maximum)

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: the HMA COBRA team, 1-800-700-7153, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or

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

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 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: 1-800-700-7153, and the 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 1-800-700-7153.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-700-7153.]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-700-7153.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-700-7153.]

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 https://www.laika.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	$1,500
Specialist copayment	$25
Hospital (facility) coinsurance	20%
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	$1,500
Copayments	$10
Coinsurance	$1,910
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,480**

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

The plan's overall deductible	$1,500
Specialist copayment	$25
Hospital (facility) coinsurance	20%
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	$0
Copayments	$660
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$680**

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

The plan's overall deductible	$1,500
Specialist coinsurance	$25
Hospital (facility) coinsurance	20%
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	$290
Copayments	$530
Coinsurance	$0
What isn't covered	
Limits or exclusions	$00
The total Mia would pay is	**$820**

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