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 Insurance Management Services. 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.imstpa.com or call 1-800-687-5944 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0 Person/ $0 Family Non-Network: Not Covered	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. Preventive care and primary care services are covered before you meet your deductible.	This plan covers certain preventive services without cost-sharing. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific deductibles.	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?	N/A	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?	Charges paid at 100%, charges above usual and customary and expenses not covered under the Plan.	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, when using a Wellness Pointe Provider	This plan uses a provider network. You will pay less if you use a provider in the plan's network. an Out-of-network providers are not covered 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.	Specialists are not 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
		Your Cost If You Use a Wellness Pointe Provider	Your Cost if you Use any Other Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Not Covered	PCP includes General Practice, Family Practice, Internal Medicine, OB/GYN, Pediatrician
	Specialist visit	Not Covered	Not Covered	Not Covered
	Preventive care/screening/ immunization	No Charge	Not Covered	Network Benefits for preventive care that are payable at 100% of Eligible Expenses (without application of any Co-Payment, Co-insurance or deductible) and apply to the following: • Evidence based items or services that have in effect a rating of "A" or "B" in the current recommendations of the USPSTF. • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease control and Prevention.
If you have a test	Diagnostic test (x-ray, blood work)	$1,000 Calendar Year Maximum	Not Covered	Not Covered except as defined under primary care visit and preventive care benefits
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	Not covered except as defined under preventive care benefits
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Limited Coverage		Generic Drugs are limited to Grade A & B as defined by the U.S. Preventive Services Task Force; Limited to a 30 day supply.
	Preferred brand drugs	Not Covered		Plan does not cover brand drugs even if a generic is not available
	Non-preferred brand drugs	Not covered		RX Co-Pays are included in the medical Out-of-Pocket maximum.
	Specialty drugs	Not Covered		Not Covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	Not Covered
	Physician/surgeon fees	Not Covered	Not Covered	Not Covered

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Your Cost If You Use a Wellness Pointe Provider	Your Cost if you Use any Other Provider	
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	Not Covered
	ER transportation	Not Covered	Not Covered	Not Covered
	Urgent care	Not Covered	Not Covered	Not Covered
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	Not Covered
	Physician/surgeon fees	Not Covered	Not Covered	Not Covered
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	Not Covered
	Inpatient services	Not Covered	Not Covered	Not Covered
If you are pregnant	Office visits	Not Covered	Not Covered	Not Covered
	Childbirth/delivery professional services	Not Covered	Not Covered	Not Covered
	Childbirth/delivery facility services	Not Covered	Not Covered	Not Covered
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	Not Covered
	Rehabilitation services	Not Covered	Not Covered	Not Covered
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Not Covered	Not Covered	Not Covered
	Durable medical equipment	Not Covered	Not Covered	Not Covered
	Hospice services	Not Covered	Not Covered	Not Covered
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

* For more information about limitations and exceptions, see the plan or policy document at www.imstpa.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.)

- Cosmetic Surgery
- Dental Care (Adult) Covered Under Dental Plan
- Infertility Treatment
- Hearing Aids
- Acupuncture
- Diabetic Education
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Chiropractic Care
- Routine Foot Care
- Weight Loss Programs
- Bariatric Surgery
- Routine Eye Care (Adult) Covered under Vision Plan

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

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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? 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 al1-800-687-5944
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa1-800-687-5944
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-687-5944
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-687-5944

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.imstpa.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	N/A
Specialist *[cost sharing]*	N/A
Hospital (facility) *[cost sharing]*	N/A
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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$4
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,694
The total Peg would pay is	**$12,698**

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

The plan's overall deductible	N/A
Specialist *[cost sharing]*	N/A
Hospital (facility) *[cost sharing]*	N/A
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	**$7,583**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$8
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,967
The total Joe would pay is	**$6,975**

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

The plan's overall deductible	N/A
Specialist *[cost sharing]*	N/A
Hospital (facility) *[cost sharing]*	N/A
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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,925
The total Mia would pay is	**$1,925**

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