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 1-563-584-4885 or toll free 1-866-821-1365. 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.mahealthcare.com or call 1-563-584-4885 or toll free 1-866-821-1365 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,000/Individual; $2,000/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, 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 are covered before you meet your deductible.	This plan may cover certain items and services even if you haven't met the deductible amount yet. 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?	Medical: $3,000/Individual; $6,000/Family; RX: $1,000/Individual; $2,000/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, health care this plan doesn't cover, infertility, out-of-network amounts that exceed UCR.	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.mahealthcare.com or call 1-800-747-8900 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, if In-Network	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	$20 copay/visit	Not covered	None
	Specialist visit	$20 copay/visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	MAHP follows the U.S. Preventive Services Task Force for preventive services. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mahealthcare.com	Tier 1 drugs	$15 copay	Not covered	Refer to the Prescription Drug Document for further coverage and limitations.
	Tier 2 drugs	$45 copay	Not covered	Refer to the Prescription Drug Document for further coverage and limitations.
	Tier 3 drugs	Not covered	Not covered	Not covered unless Medical Necessity and Prior Approval have been obtained.
	Specialty drugs	Tier 1: $15 copay Tier 2: $45 copay	Not covered	Requires Prior Approval. Includes coverage for oral chemotherapy. Refer to the Prescription Drug Document for further coverage and limitations.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not covered	None
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	None

[*For more information about limitations and exceptions, see the plan or policy document at http://ww2.mahealthcare.com/IA/2018-LG-IA.pdf.]

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 need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copay waived if admitted to hospital, but you are liable for any facility fee. Out-of-Network: Subject to Usual and Customary charges.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Medically Necessary services
	Urgent care	$20 copay/visit	$20 copay/visit	Out-of-Network: Subject to Usual and Customary charges.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not covered	Requires Prior Approval
	Physician/surgeon fees	20% coinsurance after deductible	Not covered	Requires Prior Approval
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $20 copay/visit; Outpatient: 20% coinsurance after deductible	Not covered	None
	Inpatient services	20% coinsurance after deductible	Not covered	Requires Prior Approval
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% coinsurance after deductible	Not covered	None

[*For more information about limitations and exceptions, see the plan or policy document at http://ww2.mahealthcare.com/IA/2018-LG-IA.pdf.]

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 need help recovering or have other special health needs	Home health care	No charge	Not covered	Requires Prior Approval
	Rehabilitation services	Office: $20 copay/visit; Outpatient: 20% coinsurance after deductible	Not covered	PT, OT, & Speech are limited to 30 combined visits per calendar year.
	Habilitaton services	Not covered	Not covered	Not covered
	Skilled nursing care	20% coinsurance after deductible	Not covered	Limited to 100 days per calendar year. Requires Prior Approval
	Durable medical equipment	20% coinsurance after deductible	Not covered	Rental or purchase over $500 requires prior approval.
	Hospice services	No charge	Not covered	Requires Prior Approval
If your child needs dental or eye care	Children's eye exam	$20 copay/visit	Not covered	Routine eye exams: One exam per calendar year if you are 17 and under. One exam every two calendar years if you are 18 and over. Medical eye exams: When Medically Necessary
	Children's glasses	Plan pays: $15 each single vision lens. $30 each biofocal & trifocal lens. $30 each contact lens. $60 each cataract lens. $30 frames.	Plan Pays: $15 ea sgl vision lens. $30 ea biofocal & trifocal lens. $30 ea contact lens. $60 ea cataract lens. $30 frames.	One pair of glasses or contacts per calendar year if you are 17 and under. One pair of glasses or contacts every two calendar years if you are 18 and over. (May not receive contacts and glasses during the same benefit period)
	Children's dental check-up	Not covered	Not covered	Not Covered

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.)

- Acupuncture
- Dental Care (Adult)
- Hearing Aids
- Habilitation Services
- Long-Term Care
- Non-Emergency care when traveling outside the U.S.
- Private Duty Nurse
- Weight Loss Program

[*For more information about limitations and exceptions, see the plan or policy document at http://ww2.mahealthcare.com/IA/2018-LG-IA.pdf.]

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery (If meets criteria & has Prior Approval by MAHP) • Chiropractic Care	• Cosmetic Surgery (Limited Services, Requires Prior Approval)	• Routine Eye Care (Adult)

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 are state insurance department, the U.S. Department of Labor, Employee Benefits Administration at 1-866-444-3272 or www.dol.gov/ebsa., or the U.S. Department of Health and Human Services 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 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: Member Services at 563-584-4885 or toll free at 1-866-821-1365; 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**
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? **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 (Espanol): Para obtener asistencia en Espanol, llame al 1-866-821-1365 (TTY:1-800-735-2942).]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-821-1365 (TTY:1-800-735-2942).]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-821-1365 (TTY:1-800-735-2942).]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-821-1365 (TTY:1-800-735-2942).]
---------- 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 http://ww2.mahealthcare.com/IA/2018-LG-IA.pdf.]

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	$1,000
Specialist copayment	$20
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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copays	$0
Coinsurance	$2,000
What isnt covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$1,000
Specialist copayment	$20
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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,000
Copays	$1,100
Coinsurance	$0
What isnt covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,160**

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

The plan's overall deductible	$1,000
Specialist copayment	$20
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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copays	$100
Coinsurance	$0
What isnt covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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