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, if any, 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 your employer 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 all the Glossaries at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/sbc-glossary-anchors.xlsx or call (800) 562-6900(for WA state. For other states check phone number here https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the chart starting on page 2 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.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers
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?	Not applicable	This plan does not use a provider network. You can receive covered services from any provider.
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
		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	Primary care visit to treat an injury or illness	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.

Questions: Call **1-866-897-1996** or visit us at **www.naviabenefits.com** **or** **105@naviabenefits.com**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call your employer to request a copy.

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)	
or clinic	Specialist visit	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Preventive care/screening/ immunization	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
If you have a test	Diagnostic test (x-ray, blood work)	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Imaging (CT/PET scans, MRIs)	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Preferred brand drugs	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Non-preferred brand drugs	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Specialty drugs	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Physician/surgeon fees	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
If you need immediate medical attention	Emergency room care	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Emergency medical transportation	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Urgent care	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
If you have a hospital stay	Facility fee (e.g., hospital room)	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Physician/surgeon fees	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.

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 mental health, behavioral health, or substance abuse services	Outpatient services	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Inpatient services	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
If you are pregnant	Office visits	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Childbirth/delivery professional services	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Childbirth/delivery facility services	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
If you need help recovering or have other special health needs	Home health care	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Rehabilitation services	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Habilitation services	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Skilled nursing care	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Durable medical equipment	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Hospice services	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
If your child needs dental or eye care	Children's eye exam	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Children's glasses	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.
	Children's dental check-up	0%-100%	0%-100%	Coverage is limited to HRA balance or eligibility of expense.

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 • Weight loss programs	• Cosmetic Surgery • Private-duty nursing	• Long-term Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Infertility treatment • Routine foot care	• Chiropractic care • Routine eye care (Adult & Child) • Dental care (Adult & Child)	• Hearing Aids • Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. 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:

[Non-ERISA] Navia Benefit Solutions (866) 897-1996 or www.naviabenefits.com.

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:
If you need assistance understanding this communication in a different language, please contact your employer.

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 HRAs overall deductible** **$0**
- **Plan Pays** **0-100%**
- **Patient pays** **0-100%**

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	**$5,000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	0-100%
Copayments	0-100%
Coinsurance	0-100%
What isn't covered	
Limits or exclusions	0-100%
The total Peg would pay is	**0-100%**

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

- **The HRAs overall deductible** **$0**
- **Plan Pays** **0-100%**
- **Patient pays** **0-100%**

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	**$8,000**

In this example, Joe would pay:

Cost Sharing	
Deductibles	0-100%
Copayments	0-100%
Coinsurance	0-100%
What isn't covered	
Limits or exclusions	0-100%
The total Joe would pay is	0-100%

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

- **The HRAs overall deductible** **$0**
- **Plan Pays** **0-100%**
- **Patient pays** **0-100**

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	**$4,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	0-100%
Copayments	0-100%
Coinsurance	0-100%
What isn't covered	
Limits or exclusions	0-100%
The total Mia would pay is	0-100%

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