
 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 HealthEZ at 1-800-948-3253. 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/pdf/sbcuniformglossary.pdf](http://www.dol.gov/ebsa/pdf/sbcuniformglossary.pdf) or call 1-800-948-3253 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p><b>\$5,000</b> individual/ <b>\$10,000</b> family for <u>in-network</u> providers. There is <b>no coverage</b> for <u>out-of-network</u> providers.</p>	<p>Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.  <b>Deductible year runs 10/01 to 9/30.</b></p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <a href="#">plan</a> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p><b>\$6,450</b> individual/ <b>\$12,900</b> family for <u>in-network</u> providers. There is <b>no coverage</b> for <u>out-of-network</u> providers.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p><u>Premiums</u>, <u>balance-billed</u> charges, and health care this <a href="#">plan</a> does not cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes. See <a href="http://www.ltfbenefits.com">www.ltfbenefits.com</a> or call 1-800-948-3253 for a list of <u>in-network</u> providers.</p>	<p>This <a href="#">plan</a> uses a provider <u>network</u>. You will pay less if you use a <u>provider</u> in the plan's <u>network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <a href="#">plan</a> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 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 <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	10% <a href="#">Coinsurance</a>	Not Covered	None
	<a href="#">Specialist</a> visit	10% <a href="#">Coinsurance</a>	Not Covered	Chiropractic Services: No visit limit if completed at Life Time locations.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your plan will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Preventive services: No Charge	Not Covered	None
		Non-preventive services: 10% <a href="#">Coinsurance</a>		
	Imaging (CT/PET scans, MRIs)	10% <a href="#">Coinsurance</a>	Not Covered	<a href="#">Precertification</a> required
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ltfbenefits.com">www.ltfbenefits.com</a>	Generic drugs	Retail & Mail order: 10% <a href="#">Coinsurance</a>		Retail and mail order available up to 90-day supply
	Preferred brand drugs	Retail & Mail order: 10% <a href="#">Coinsurance</a>		Retail and mail order available up to 90-day supply
	Non-preferred brand drugs	Retail & Mail order: 10% <a href="#">Coinsurance</a>		Retail and mail order available up to 90-day supply
	<a href="#">Specialty drugs</a>	Retail & Mail order: 10% <a href="#">Coinsurance</a>		Retail and mail order available up to 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">Coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required for procedures performed outside of a physician's office. <a href="#">Out-of-network</a> elective surgery is not covered.
	Physician/surgeon fees	10% <a href="#">Coinsurance</a>	Not Covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">Coinsurance</a>	Covered as in-network in true emergencies	True emergency covered at in-network level
	<a href="#">Emergency medical transportation</a>	10% <a href="#">Coinsurance</a>	Not Covered	True emergency covered at in-network level
	<a href="#">Urgent care</a>	10% <a href="#">Coinsurance</a>	Not Covered	None

\* For more information about limitations and exceptions, see the plan or policy document at [www.ltfbenefits.com](http://www.ltfbenefits.com).

<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>Coinsurance</u>	Not Covered	<u>Preauthorization</u> required
	Physician/surgeon fees	10% <u>Coinsurance</u>	Not Covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	10% <u>Coinsurance</u>	Not Covered	None
	Inpatient services	10% <u>Coinsurance</u>	Not Covered	<u>Preauthorization</u> required
<b>If you are pregnant</b>	Office visits	No Charge	Not Covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>Coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	10% <u>Coinsurance</u>	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>Coinsurance</u>	Not Covered	<u>Preauthorization</u> required 100 visit limit per year.
	<u>Rehabilitation services</u>	10% <u>Coinsurance</u>	Not Covered	30 visit limit per therapy per year. <u>Preauthorization</u> required for occupational or speech therapy.
	<u>Habilitation services</u>	10% <u>Coinsurance</u>	Not Covered	<u>Preauthorization</u> required for physical therapy visits in excess of annual limit. No visit limit per therapy if completed at Life Time locations.
	<u>Skilled nursing care</u>	10% <u>Coinsurance</u>	Not Covered	<u>Preauthorization</u> required 90-day limit per year.
	<u>Durable medical equipment</u>	10% <u>Coinsurance</u>	Not Covered	<u>Precertification</u> required for charges in excess of \$1,000.
	<u>Hospice services</u>	10% <u>Coinsurance</u>	Not Covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	Limit of 1 routine exam per year.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

#### **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
- Weight loss programs
- Routine Foot Care
- Dental Care
- Hearing Aids
- Bariatric Surgery
- Acupuncture
- Long-term care
- Non-emergency care when traveling outside the U.S.

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

- Infertility Treatment (correction of physiological abnormalities)
- Routine Eye Care (one visit/yr)
- Emergency care when traveling outside the U.S.
- Chiropractic Care (in-network only)
- Private Duty Nursing (inpatient only)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the [plan](#) at 1-800-948-3253. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), your state insurance department, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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: HealthEZ at 1-800-948-3253 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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 (Español): Para obtener asistencia en Español, llame al 1-800-948-3253

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-948-3253

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-948-3253

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-948-3253

—————*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 [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) [coinsurance](#) 10%
- [Hospital \(facility\)](#) [coinsurance](#) 10%
- [Other](#) [coinsurance](#) 10%

**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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$1,260
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,320</b>

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) [coinsurance](#) 10%
- [Hospital \(facility\)](#) [coinsurance](#) 10%
- [Other](#) [coinsurance](#) 10%

**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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$720
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$5,780</b>

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist](#) [coinsurance](#) 10%
- [Hospital \(facility\)](#) [coinsurance](#) 10%
- [Other](#) [coinsurance](#) 10%

**This EXAMPLE event includes services like:**  
 Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,368</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,230
Copayments	\$0
Coinsurance	\$140
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,370</b>