
 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 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/healthreform](http://www.dol.gov/ebsa/healthreform) or call 800-948-3253 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network providers</a> : \$1,500/individual or \$3,000/family <a href="#">Out-of-network provider</a> : <b>Not Covered</b>	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. The <a href="#">deductible</a> is <b>Embedded</b> . If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . <b>Deductible year runs 10/01 – 09/30</b>
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This plan covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive care</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive</a> services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network providers</a> : \$2,800/individual or \$5,600/family <a href="#">Out-of-network providers</a> : <b>Not Covered</b>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. The <a href="#">out-of-pocket limit</a> is <b>Embedded</b> . If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.LTFBenefits.com">www.LTFBenefits.com</a> or call 800-948-3253 for a list of <a href="#">network providers</a> .	This plan uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ).
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copayment</a>	Not Covered	<a href="#">Deductible</a> does not apply to <a href="#">copayment</a> .
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a>	Not Covered	<a href="#">Deductible</a> does not apply to <a href="#">copayment</a> .
	<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 <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	Not Covered	<a href="#">Diagnostic tests</a> completed at an independent laboratory or clinic are covered at no charge.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not Covered	May require <a href="#">preauthorization</a> .
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.LTFBenefits.com</a>	Generic drugs	Retail: \$15 <a href="#">copayment/Prescription</a> Mail Order: \$45 <a href="#">copayment/Prescription</a>		<a href="#">Cost sharing</a> does not apply for <a href="#">preventive Prescriptions</a> . Retail & Mail Order available up to a 90-day supply. <a href="#">Deductible</a> does not apply to <a href="#">copayment</a> .
	Preferred brand drugs	Retail: \$60 <a href="#">copayment/Prescription</a> Mail Order: \$180 <a href="#">copayment/Prescription</a>		
	Non-preferred brand drugs	Retail: \$90 <a href="#">copayment/Prescription</a> Mail Order: \$270 <a href="#">copayment/Prescription</a>		
	<a href="#">Specialty drugs</a>	Retail & Mail Order: 30% <a href="#">coinsurance</a>		Retail & Mail Order available up to a 30-day supply. <a href="#">Deductible</a> does not apply to <a href="#">coinsurance</a> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not Covered	May require <a href="#">preauthorization</a> .
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$300 <a href="#">copayment</a> , then 20% <a href="#">coinsurance</a>	Not Covered	True emergency covered at in-network level.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	Not Covered	True emergency covered at in-network level.
	<a href="#">Urgent care</a>	\$50 <a href="#">copayment</a>	Not Covered	<a href="#">Deductible</a> does not apply to <a href="#">copayment</a> .
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not Covered	None.

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

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)		
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$50 <a href="#">copayment</a>	Not Covered	Any <a href="#">provider</a> is treated as in-network for office visits. <a href="#">Deductible</a> does not apply to <a href="#">copayment</a> .	
	Inpatient services	20% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required.	
<b>If you are pregnant</b>	Office visits	No charge	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive</a> services. Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC.	
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	Not Covered		
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	Not Covered		
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not Covered	Chiropractic Services: 30 visit limit/year. No visit limit for services completed at Life Time, Inc. locations. <a href="#">Deductible</a> does not apply to <a href="#">copayment</a> .	
	<a href="#">Rehabilitation services</a>	Occupational & Speech Therapy: \$50 <a href="#">copayment</a>	Not Covered		
	<a href="#">Habilitation services</a>	Chiropractic Services: \$50 <a href="#">copayment</a>	Not Covered		
		Physical Therapy: \$25 <a href="#">copayment</a>			
		Chiropractic Services & Physical Therapy at Life Time, Inc.: \$15 <a href="#">copayment</a>			
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Not Covered		<a href="#">Preauthorization</a> required. 90 days per year maximum.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not Covered		None.
<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> required.		
<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.	

\* For more information about limitations and exceptions, see the plan or policy document at [www.LTFBenefits.com](http://www.LTFBenefits.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
- Weight loss programs
- Hearing Aids
- 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)
- Acupuncture
- Emergency care when traveling outside the U.S.
- Chiropractic Care
- 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. The contact information for those agencies is: 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). 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: : 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).

#### 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 800-948-3253

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

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

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 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](#) \$1,500
- [Specialist copayment](#) \$50
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,860</b>

**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](#) \$50
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$964
Coinsurance	\$336
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,855</b>

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$50
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$300
Coinsurance	\$172
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,972</b>