
 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 or call 800-948-3253 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network providers : \$1,500/individual, \$3,000/family Out-of-network provider : N/A	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. The deductible is Embedded . 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 . Deductible year runs 10/01 – 09/30
Are there services covered before you meet your deductible ?	Yes. Preventive care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive care 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 ?	Network providers : \$2,800/individual, \$5,600/family Out-of-network providers : N/A	The out-of-pocket limit is the most you could pay in a year for covered services. The out-of-pocket limit is Embedded . 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 , balance billing charges, and health care this plan doesn't cover.	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 http://www.LTFBenefits.com or call 800-948-3253 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).
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 or clinic	Primary care visit to treat an injury or illness	\$25 copayment	Not covered	Deductible does not apply to copayment .
	Specialist visit	\$50 copayment	Not covered	Deductible does not apply to copayment .
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	Diagnostic tests associated with office visits are covered at no charge.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	May require preauthorization
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.LTFBenefits.com	Generic drugs	30-day supply Retail: \$15 copayment/Prescription 90-day supply Mail Order: \$45 copayment/Prescription		Cost sharing does not apply for preventive Prescriptions . Deductible does not apply to copayment . Retail & Mail Order available up to a 90-day supply.
	Preferred brand drugs	30-day supply Retail: \$60 copayment/Prescription 90-day supply Mail Order: \$180 copayment/Prescription		
	Non-preferred Brand drugs	30-day supply Retail: \$90 copayment/Prescription 90-day supply Mail Order: \$270 copayment/Prescription		
	Specialty drugs	30-day supply Retail & Mail Order: 30% coinsurance/Prescription		Retail & Mail Order available up to a 30-day supply.

* 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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	May require preauthorization .
	Physician/surgeon fees	20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	\$300 copayment , then 20% coinsurance	Not covered	Deductible does not apply to copayment . True emergency covered at in-network level.
	Emergency medical transportation	20% coinsurance	Not covered	True emergency covered at in-network level.
	Urgent care	\$50 copayment	Not covered	Deductible does not apply to copayment .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Preauthorization required.
	Physician/surgeon fees	20% coinsurance	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 copayment		Deductible does not apply to copayment .
	Inpatient services	20% coinsurance	Not covered	Preauthorization required.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Preauthorization required.
	Rehabilitation services	Occupational & Speech Therapy: \$50 copayment	Not covered	
	Habilitation services	Chiropractic Services: \$50 copayment Chiropractic Services & Physical Therapy at Life Time, Inc.: \$15 copayment	Not covered	Chiropractic Services: 30 visit limit/year. No visit limit for services completed at Life Time, Inc. locations. Deductible does not apply to copayment .
	Skilled nursing care	20% coinsurance	Not covered	Preauthorization required. 90 days per year maximum
	Durable medical equipment	20% coinsurance	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)	
	Hospice services	20% coinsurance	Not covered	Preauthorization required.
If your child needs dental or eye care	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
- Dental Care (Adult)
- Hearing Aids
- Bariatric Surgery
- 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 exam/year)
- Routine Foot Care
- 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. 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: : 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

[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

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

[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 test](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

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
The total Peg would pay is	\$2,860

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 test](#) (*blood work*)
- Prescription drugs
- [Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$1,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,120

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*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$500
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,050