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, visit www.thriventhealthnavigator.com or by calling 1-888-981-8488. 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.thriventhealthnavigator.com or call 1-888-981-8488 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person / **$4,000** person + spouse or child(ren) / **$6,000** family In-network **$3,000** person / **$6,000** person + spouse or child(ren) / **$9,000** family Out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Prescription Drugs, In-network Preventive care and in- and out-of-network Prenatal 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 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?	**$3,000** person / **$6,000** person + spouse or child(ren) / **$9,000** family In-network **$4,000** person / **$8,000** person + spouse or child(ren) / **$12,000** family Out-of-network **$6,550** In-network / **$6,550** Out-of-network Maximum amount that any one person will satisfy towards the annual family out-of-pocket	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?	Penalties, 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 www.thriventhealthnavigator.com or call 1-888-981-8488 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 (a 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.	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
		In-network (You will pay the least)	Out-of-network (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% Coinsurance	35% Coinsurance	None
	Specialist visit	25% Coinsurance	35% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible waived	No charge; Deductible waived to age 18; 35% Coinsurance from age 18	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)	25% Coinsurance	35% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% Coinsurance	35% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service Out-of-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.thriventhealthnavigator.com	Generic drugs (Tier 1)	Preventive list drugs: Retail: $10 copay Mail Order: $25 Copay All other Retail & Mail Order: 25% Coinsurance.	Preventive list drugs: $10 Copay retail All other Retail: 25% Coinsurance	Cost sharing for non-preferred generic retail and mail order drugs is not displayed. No coverage for mail order drugs from Out-of-Network providers. For additional information, call MyQHealth at 1-888-981-8488
	Preferred brand drugs (Tier 2)	Preventive list drugs: Retail: 25% Coinsurance ($30 minimum/$70 maximum); Mail Order: 25% Coinsurance ($60 minimum/$140 maximum). All other Retail & Mail Order: 25% Coinsurance.	Preventive list drugs: Retail: 25% Coinsurance ($30 minimum/$70 maximum). All other Retail: 25% Coinsurance Mail Order: Not Covered.	
	Non-preferred brand drugs (Tier 3)	Retail & Mail Order: 25% Coinsurance	Retail: 25% Coinsurance Mail Order: Not Covered	
	Specialty drugs (Tier 4)	Refer to applicable prescription drug cost sharing available at www.thriventhealthnavigator.com	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% Coinsurance	35% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service Out-of-network.
	Physician/surgeon fees	25% Coinsurance	35% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need immediate medical attention	Emergency room care	25% Coinsurance	25% Coinsurance	In-network deductible applies to Out-of-network benefits
	Emergency medical transportation	25% Coinsurance	25% Coinsurance	In-network deductible applies to Out-of-network benefits; $25,000 Maximum benefit per occurrence air ambulance
	Urgent care	25% Coinsurance	35% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% Coinsurance	35% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service Out-of-network.
	Physician/surgeon fee	25% Coinsurance	35% Coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	25% Coinsurance	35% Coinsurance	
	Inpatient services	25% Coinsurance	35% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service Out-of-network.
If you are pregnant	Office visits	Prenatal: No charge; Deductible waived Postnatal: 25% Coinsurance	Prenatal: No charge Postnatal: 35% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% Coinsurance	35% Coinsurance	
	Childbirth/delivery facility services	25% Coinsurance	35% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	25% Coinsurance	35% Coinsurance	180 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service Out-of-network.
	Rehabilitation services	25% Coinsurance	35% Coinsurance	Covered only for OT/PT/ST/RT/Cardiac and Cardiac Pulmonary Rehab
	Habilitation services	25% Coinsurance	35% Coinsurance	Covered only for OT/PT/ST/RT/Cardiac and Cardiac Pulmonary Rehab
	Skilled nursing care	25% Coinsurance	35% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service Out-of-network.
	Durable medical equipment	25% Coinsurance	35% Coinsurance	Preauthorization is required for DME in excess of $1,500 for purchases & all rentals. If you don't get preauthorization, benefits could be reduced by 20% per occurrence Out-of-network.
	Hospice service	25% Coinsurance	35% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service Out-of-network.
If your child needs dental or eye care	Children's eye exam	No charge; Deductible waived	35% Coinsurance	1 Maximum exam per calendar year
	Children's glasses	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (covered only for the treatment of chronic pain; and, nausea associated with surgery, chemotherapy, or pregnancy)
- Bariatric surgery
- Chiropractic care
- Hearing aids (to age 18 who have a hearing loss that cannot be corrected by other covered procedures)
- Infertility treatment (Lifetime maximum $10,000 medical, $12,000 prescription drug)
- Non-emergency care when traveling outside the U.S.
- 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 is: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.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 on how 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 Standard? **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 1-888-981-8488.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-981-8488.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-981-8488.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-981-8488.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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	$2,000
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$2,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$3,100**

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

The plan's overall deductible	$2,000
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$2,000
Copayments	$150
Coinsurance	$850
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,060**

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

The plan's overall deductible	$2,000
Specialist coinsurance	25%
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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