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 these websites*. For 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 https://www.healthcare.gov/sbc-glossary/ or **call 1-(833) 997-1084.**

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0	See the Common Medical Events chart below for a partial list of costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	There is no deductible, but a copayment may apply. For example, this plan covers certain preventive services without cost-sharing. 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 covered services.
What is the out-of-pocket limit for this plan?	Medical: For network providers: $6,000 individual / $12,000 family For out-of-network providers: $12,000 individual / $24,000 family Prescription: $1,500 individual / $3,000 family	The out-of-pocket limit is the most you could pay in a plan year for covered services. Copayments for covered health care services and copayments for covered prescriptions, count toward your out-of-pocket limit. 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. Medical and Prescription out-of-pocket limit are separate and do not track together.
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.	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). 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.

* During open enrollment, visit choosebind.com/PetSmart and use one of the following access codes: for Active use **petsmart2021**. After you enroll, see the plan documents, download the MyBind app, visit the MyBind.com website, or call Bind Help for more detailed coverage information, including without limitation a specific copayment for a specific service, plan limitations and exceptions, and other important cost and coverage information.

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	$60 - $240 copayment/visit	$480 copayment/visit	Certain procedures performed in the office may have a higher copayment.
	Specialist visit	$60 - $240 copayment/visit	$480 copayment/visit	
	Preventive care/screening/ immunization	No charge	$330 copayment/visit	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 (e.g. x-ray, blood work)	No charge	No charge	Higher copayments apply to genetic testing.
	Imaging (CT/PET scans, MRIs)	$500 - $1,500 copayment/visit	$2,400 copayment/visit	Multiple copayments may apply if more than one body part is scanned during a visit. Preauthorization is required for certain imaging tests.

‡ The full range of copayment may not be available in all areas or for all services.
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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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	**Generic drugs**	**30-Day Supply** $7 copayment **90-Day Supply** $18 copayment	Not covered	Certain Preventive generic drugs are available with $0 copayments, including prescribed generic contraceptives and tobacco cessation medications. To learn more about drug tiers and about copayments for specific drugs, visit www.caremark.com. Preauthorization is required for certain drugs.
	Preferred Brand drugs	**30-Day Supply** 25% copayment to $25 minimum/$150 maximum **90-Day Supply** $75 copayment	Not covered	
	Non-Preferred Brand drugs	**30-Day Supply** 40% copayment to $50 minimum/$250 maximum **90-Day Supply** $400 copayment	Not covered	
	Specialty drugs	**30-Day Supply** $0 copayment if enrolled in PrudentRx, otherwise Specialty drugs: 30% coinsurance	Not covered	Specialty drugs are not covered at 90-day supplies. Preauthorization is required for certain Specialty drugs.

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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 access (e.g., ambulatory surgery center)	Up to $4,100 copayment/visit	Up to $8,200 copayment/visit	Copayments are based on provider, procedure/service, and service location. Preauthorization is required for certain outpatient services.
	Physician/surgeon fees	Included in the facility copayment	Included in the facility copayment	
If you need immediate medical attention	Emergency room care	$1,500 copayment/visit	$1,500 copayment/visit	Copayment is waived if admitted within 24 hours.
	Emergency medical transportation	$1,600 copayment/trip	$1,600 copayment/trip	None
	Urgent care	$100 copayment/visit	$240 copayment/visit	None
If you have a hospital stay	Facility access (e.g., hospital room)	Up to $5,000 copayment/visit	Up to $10,000 copayment/visit	Copayments are based on provider, procedure/service, and service location. Preauthorization is required for non-emergency facility admissions and inpatient surgery.
	Physician/surgeon services	Included in the facility copayment	Included in the facility copayment	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Home/Office**: $60 copayment/visit **Outpatient Hospital**: Up to $2,000 copayment/visit	**Home/Office**: $120 copayment/visit **Outpatient Hospital**: Up to $4,000 copayment/visit	Certain procedures/services in the outpatient setting may have a lower copayment. Preauthorization is required for certain outpatient services.
	Inpatient services	$4,000 copayment/stay	$8,000 copayment/stay	Preauthorization is required for certain inpatient services.

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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 are pregnant	Routine pre- and post-natal office visits	No charge	$330 copayment/visit	Cost sharing does not apply to preventive services with network providers.
	Childbirth/delivery professional services	Included in the facility copayment	Included in the facility copayment	One copayment for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother.
	Childbirth/delivery facility services	$3,000 - $5,000 copayment/stay	$10,000 copayment/stay	
If you need help recovering or have other special health needs	Home health care	$50 copayment/visit	$140 copayment/visit	Visit Limit: 100 for Home health care per person per plan year (visit limits are a combination of network providers and out-of-network provider) Preauthorization is required for certain home health care services.
	Rehabilitation services	$20 - $50 copayment/visit	$100 copayment/visit	Visit limits per person per plan year, are a combination of network providers and out-of-network providers. 60 visit limit for occupational therapy 60 visit limit for physical therapy 60 visit limit for speech therapy Cardiac Rehab and Pulmonary Rehab $50 copayment network providers $100 copayment out-of-network providers.
	Habilitation services	$20 - $50 copayment/visit	$100 copayment/visit	

‡ The full range of copayment may not be available in all areas or for all services.
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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 help recovering or have other special health needs	Skilled nursing care	$3,000 copayment/stay	$9,000 copayment/stay	Visit Limit: 120 days for Skilled nursing care per person per plan year. (the day limit is a combination of network providers and out-of-network providers)
	Durable medical equipment (DME)	$0 - $1,000 copayment/ equipment based on DME tier	$20 - $2,000 copayment/ equipment based on DME tier	For DME tiers and limitations, visit one of the Bind websites listed in the footnote on page 1. Preauthorization is required for certain DME.
	Hospice services	**Home**: $130 copayment **Inpatient**: $4,000 copayment	**Home**: $260 copayment **Inpatient**: $8,000 copayment	Preauthorization is required for certain hospice services.
If your child needs dental or eye care	Children's eye exam	$0 copayment/visit	$480 copayment/visit	One visit per person per plan year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Long term care	• Private duty nursing
• Dental care (routine)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (30 visits limit per person per plan year)	• Chiropractic care (30 visits limit per person per plan year)	• Routine eye care (Adult) one visit per person per plan year)
• Bariatric surgery	• Hearing aids (once per ear every 36 months)	• Routine foot care (for certain conditions)
	• Infertility Treatment (limitations apply)	

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 the agency is the Department of Labor's Employee Benefit 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: Bind at 1-(833) 997-1084; or the 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 of other individual market policies, Medical, 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 1-(833) 997-1084.

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	$0
Specialist copayment	$0
Hospital (facility) copayment	$5,000
Other copayments	$580

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	**$12,700**

In this example, Peg would pay:

Cost sharing	
Deductibles	$0
Copayments	$5,580
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$5,600**

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

The plan's overall deductible	$0
Specialist copayment	$220
Hospital (facility) copayment	$0
Other copayments	$2,280

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	**$5,600**

In this example, Joe would pay:

Cost sharing	
Deductibles	$0
Copayments	$2,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,500**

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

The plan's overall deductible	$0
Specialist copayment	$440
Hospital (facility) copayment	$1,500
Other copayments	$860

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	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$0
Copayments	$2,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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