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 Tall Tree Administrators. 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.talltreehealth.com or call 1-877-453-4201 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers $0 Individual / $0 family Out-of-Network Providers $500 Individual / $1,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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.
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 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.	No.
What is the out-of-pocket limit for this plan?	Network Providers $6,500/Individual / $13,000 family; Out-of-Network Providers Unlimited for Individual and Family	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?	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.talltreehealth.com or call 1-877-453-4201 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). 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.	No.

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	$20 copay	Deductible, then 40%	Per Plan Provisions
	Specialist visit	$40 copay	Deductible, then 40%	
	Preventive care/screening/ immunization	No charge	Deductible, then 60%	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)	$50 copay	Deductible, then 40%	Per Plan Provisions
	Imaging (CT/PET scans, MRIs)	$400 copay	Deductible, then 40%	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com	Generic drugs (Tier 1)	$10 copay	No Benefit	Covers up to a 30-day supply.
	Preferred brand drugs (Tier 2)	No Benefit	No Benefit	Per Plan Provisions
	Non-preferred brand drugs (Tier 3)	No Benefit	No Benefit	
	Specialty drugs (Tier 4)	No Benefit	No Benefit	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Benefit	No Benefit	Per Plan Provisions
	Physician/surgeon fees	No Benefit	No Benefit	
If you need immediate medical attention	Emergency room care	No Benefit	No Benefit	Per Plan Provisions
	Emergency medical transportation	No Benefit	No Benefit	
	Urgent care	$50 copay	Deductible, then 40%	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Benefit	No Benefit	Per Plan Provisions
	Physician/surgeon fees	No Benefit	No Benefit	

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 mental health, behavioral health, or substance abuse services	Outpatient services	No Benefit	No Benefit	Per Plan Provisions
	Inpatient services	No Benefit	No Benefit	
If you are pregnant	Office visits	No Benefit	No Benefit	Per Plan Provisions
	Childbirth/delivery professional services	No Benefit	No Benefit	
	Childbirth/delivery facility services	No Benefit	No Benefit	
If you need help recovering or have other special health needs	Home health care	No Benefit	No Benefit	Per Plan Provisions
	Rehabilitation services	No Benefit	No Benefit	
	Habilitation services	No Benefit	No Benefit	
	Skilled nursing care	No Benefit	No Benefit	
	Durable medical equipment	No Benefit	No Benefit	
	Hospice services	No Benefit	No Benefit	
If your child needs dental or eye care	Children's eye exam	No Charge	No Benefit	Per Plan Provisions
	Children's glasses	No Benefit	No Benefit	
	Children's dental check-up	No Benefit	No Benefit	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.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery Cosmetic Surgery
- Chiropractic Care
- Dental Care
- Infertility Treatment
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- 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.)

- Preventive Services identified by Centers for

Medicare and Medicaid Services (CMS)

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 Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323, extension 61565 or 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 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: [insert applicable contact information from instructions].

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 Minimum Value Standards? **No**.
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 1-877-453-4201.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-453-4201.]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-877-453-4201.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-453-4201.]

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	$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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

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

The plan's overall deductible	$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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$800
Copayments	$1,200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,360**

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

The plan's overall deductible	$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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$700
Copayments	$50
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: NOT APPLICABLE
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

Summit Express, Inc.
Enhanced Minimum Essential Coverage (Enhanced MEC) Plan
Schedule of Medical Benefits
Option ID: SUE7C

TALL TREE ADMINISTRATORS

Group ID: ESUEI

This Plan provides Minimal Essential Coverage for Medical Care.
If the service is not listed on this Schedule of Benefits it is not covered.

Claims Address
P.O. Box 1807
Draper, Utah 84020
Emdeon Payor ID: 88067
Customer Service: 877-453-4201

PPO Provider Network:
PHCS Specific Services Network

Coverage begins the 1st day of the month following 60 days of employment. Coverage ends the last day of the month following termination.
Minimum weekly hours for full time: 30 hours/130 per month

Lifetime Max: None	Network Providers	Non-Network Providers	Benefit Limits Per Plan Year
Annual Deductibles **Does not include Co-pays.** **In-network and Out-of-network are separate accumulations and do not cross apply**	Individual: None Family: None	Individual $500 Family $1,000	**All benefits and accumulations are on a Plan Year.** **Beginning December 1 and ending November 30.** **All limits and accumulations are per person per plan year.**
Annual Co-pay and Co-Insurance Out of Pocket Maximums (Medical and Rx Co-pays apply to the annual out of pocket maximums)	Individual $6,500 Family $13,000	Individual: Unlimited Family: Unlimited	
Office Visits - Primary Care (exam or consultation)	$20 Co-pay, Plan pays 100%	Deductible, Plan pays 60% of allowed amount	
Office Visits - Specialist (exam or consultation)	$40 Co-pay, Plan pays 100%	Deductible, Plan pays 60% of allowed amount	
Telemedicine	Plan pays 100%		Physicians available 24 hours a day, seven days a week if you call 800-835-2362.
Diagnostic Services - Basic labs/x-rays (related to office visit, LabCorp, etc.)	$50 Co-pay, Plan pays 100%	Deductible, Plan pays 60% of allowed amount	
Diagnostic Services - Major (Facility/Physician Charges) (MRI, CT, PET, Nuclear Medicine,etc.)	$400 Co-pay, Plan pays 100% of allowed amount	Deductible, Plan pays 60% of allowed amount	
Diagnostic Services - Minor (ultrasounds, bone density, echography, etc)	$50 Co-pay Plan pays 100%	Deductible, Plan pays 60% of allowed amount	
Emergency Room Facilities	No Benefit		
Emergency Room - All covered services other than facility charges	No Benefit		
Urgent Care Center & 24 Hour Clinic	$50 Co-pay, Plan pays 100%	Deductible, Plan pays 60% of allowed amount	
Covered Preventive Services for Adults as defined by CMS Preventive Services			
Wellness Office Visits and Lab Services	**Network Providers**	**Non-Network Providers**	**Benefit Limits**
Office Visit Exam & Includes Services For:	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Limited to preventive diagnosis only.
Abdominal Aortic Aneurysm	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	One time screening for males of ages 65 to 75 who have ever smoked
Alcohol Misuse Screening and Counseling	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	
Aspirin use for Men and Women	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	One Aspirin use consultation for women ages 45 to 79 and men 55 to 79
Blood Pressure Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	One screening every two years for ages 18 to 39 One Screening per plan year for ages 40 and over
Cholesterol Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	One screening per plan year for men 35 and older. Men under 35 who have heart disease or risk factors for heart disease or women who have heart disease or risk factors for heart disease
Colorectal Cancer Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Screening for adults over age 50

Depression Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	
Type 2 Diabetes Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Screening for adults with high blood pressure only
Diet Counseling	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Screening for adults at higher risk of chronic disease
Hepatitis B Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For members at high risk, including members in countries with 2% or more Hepatitis B prevalence, and U.S. Born people not vaccinated as infants and with at least on parent born in a region with 8% or more Hepatitis B prevalence
Hepatitis C Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For adults at increased risk, and one time for everyone born between 1945 - 1965
HIV Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Screening for adults at higher risk
Immunizations * Hepatitis A * Hepatitis B * Herpes Zoster * Human Papillomavirus * Influenza (Flu Shot) * Measles, Mumps, Rubella * Meningococcal * Pneumococcal * Tetanus, Diphtheria, Pertussis * Varicella	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Listed immunizations are once per plan year. Human Papillomavirus shots up to age 26. Pneumococcal shots for adults 65 and older
Lung Cancer Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For adults 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
Obesity Screening and Counseling	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	
Sexually Transmitted Infection (STI) Screening and Counseling	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Prevention counseling for adults at higher risk
Syphilis Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For all adults at higher risk
Tobacco Use Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Screenings for adults and cessation interventions for tobacco users
Covered Preventive Services for Women - Including Pregnant Women			
Wellness Office Visits and Lab Services	**Network Providers**	**Non-Network Providers**	**Benefit Limits**
Well-Women Visits	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	
Anemia Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For pregnant women
BRCA Counseling	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Includes genetic test for women at high risk
Breast Cancer Mammography Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Screenings every 1 to 2 years for women over 40 years old
Breast Cancer Chemoprevention Counseling	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Counseling for women at high risk
Breast Pumps	Plan pays 100%		One per delivery. Purchase Breast Pump at a local retail store and submit the receipt for reimbursement
Breastfeeding Consultations	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
Cervical Cancer Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Women ages 21 to 29 pap test every 3 years Women ages 30 to 65 every 3 years if you only have a pap test Every 5 years if you have both a pap test and an HPV test Women age 66 and older consult your doctor
Chlamydia Infection Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For younger women and women at high risk
Contraception	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	Includes birth control pills and devices, injections and surgical sterilization (hospital, physician, anesthesia)
Domestic and Interpersonal Violence Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	

Folic Acid Supplements	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For pregnant women
Gestational Diabetes Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For women 24 to 28 weeks pregnant and/or at high risk of developing gestational diabetes
Gonorrhea Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For all women at higher risk
Hepatitis B Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For pregnant women at their first prenatal visit
Human Immunodeficiency Virus (HIV) Screening and counseling	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For women sexually active
Human Papillomavirus (HPV) DNA Test	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	One test every 3 years for women with normal cytology results who are 30 or older
Osteoporosis Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For women over age 60 or at high risk
Rh Incompatibility Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For pregnant women and follow-up testing for women at higher risk
Tobacco Use Screening and interventions	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	
Syphilis Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For all pregnant women or other women at increase risk
Sexually Transmitted Infection (STI) Screening and Counseling.	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For sexually active women
Urinary Tract or Other Infection Screening for Pregnant Women	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	
Covered Preventive Services for Children			
Wellness Office Visits and Lab Services	**Network Providers**	**Non-Network Providers**	**Benefit Limits**
Alcohol and Drug Use Assessments	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	
Autism Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children at 18 months to 24 months
Behavioral Assessments	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children to age 18
Blood Pressure Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children to age 18
Cervical Dysplasia Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For sexually active females
Congenital Hypothyroidism Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For newborns
Depression Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For teenagers ages 12 to 18
Developmental Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children under age 3 and surveillance throughout childhood
Dyslipidemia Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children at high risk of lipid disorders
Fluoride Chemoprevention Supplements	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children without fluoride in their water sources
Gonorrhea Preventive Medication for the Eyes of All Newborns	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	
Hearing Screenings	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For all newborns
Height, Weight and Body Mass Index Measurements	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children to age 18
Hematocrit or Hemoglobin Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children to age 18
Hemoglobinopathies of Sickle Cell Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For all newborns
HIV Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For sexually active children
Hypothyroidism Screening for Newborns	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	

Immunizations * Diphtheria, Tetanus, Pertussis * Haemophilus influenza type B * Hepatitis A * Hepatitis B * Human Papillomavirus * Inactivated Poliovirus * Influenza (Flu Shot) * Measles, Mumps, Rubella * Meningococcal * Pneumococcal * Rotavirus * Varicella	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children to age 18
Iron Supplements	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children ages 6 to 12 months at risk of anemia
Lead Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children at risk of exposure
Medical History	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For all children throughout development
Obesity Screening and Counseling	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children to age 18
Oral Health	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	At risk assessment for your children ages newborn to age 10
Phenylketonuria (PKU) Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For genetic disorders in newborns
Sexually Transmitted Infection (STI) Screening and Counseling	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children at higher risk, includes gonorrhea preventive medication for newborn eyes
Tuberculin Testing	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children at higher risk of tuberculosis to age 18
Vision Screening	Plan pays 100%	Deductible, Plan pays 40% of allowed amount	For children to age 18
Prescription Benefits			
Covered Prescription Drugs - MagellanRx Management, A Member of The Clean Health Project Pharmacy Member Services: 1-800-424-0472 or www.magellanrx.com Rx Bin #: 017449 Rx PCN #: 6792000 RxGRP: PRXTTA	Generic: $10 Co-pay Formulary Brand: No Benefit Non-Formulary Brand: No Benefit	No Benefit	No specialty medications are covered. Discount available for all non covered prescriptions when utilizing a MagellanRx Pharmacy

Effective: 12/1/2017

Dependents covered to age 26 regardless of student or marital status.

Timely Filing: Claims must be filed within 12 months from the date the service incurred.

Rural Area is defined as 30 miles. If preventive services are not available within 30 miles of your residence the provider will be paid in network.

Coordination of Benefits: Non duplicating, Plan does not pay in excess of what the plan would have paid without other coverage.

We believe this coverage is a Non-Grandfathered health plan under the Patient Protection and Affordable Care Act. (PPACA)

Visit ***www.talltreehealth.com*** to view Schedule of Benefits, Plan Document, Enrollment information, claims history, link to the PPO Network and more.

All claims are subject to Plan provisions at the time of service. Any benefits quoted telephonically or in writing is not a guarantee of payment.

Claims are determined upon receipt of the claim and any additional information required to make a benefit determination.