



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, [insert contact information]. 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.\[insert\].com](#) or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$4,000 / individual or \$8,000 / 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 and primary 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	Not Applicable
What is the out-of-pocket limit for this plan ?	For network providers \$8,500 individual / \$17,100 family; for out-of-network providers Not Limited	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 ?	Copayments for certain services, 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. Call 1-855-411-4237 for help finding a network provider.	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 ?	Sometimes (see Summary Plan Document)	Sometimes, this plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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	\$35 copay /office visit; deductible does not apply	100% coinsurance , 50% after deductible	None
	Specialist visit	\$70 copay /visit	100% coinsurance , 50% after deductible	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Preventive care/screening/immunization	No charge	No charge	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)	100% then 35% after deductible/ per test	100% then 50% after deductible/ per test	None
	Imaging (CT/PET scans, MRIs)	100% then 35% after deductible/ per test	100% then 50% after deductible/ per test	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs (Tier 1)	\$5 copay /prescription (retail & mail order)	Not Covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	\$45 copay /prescription (retail & mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	\$75 copay /prescription (retail & mail order)	Not Covered	
	Not Covered	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% after deductible	50% after deductible	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	35% after deductible	50% after deductible	50% coinsurance for anesthesia.
If you need immediate medical attention	Emergency room care	\$400 copay /then 35% after deductible	\$400 copay /then 25% after deductible	None
	Emergency medical transportation	100% of cost, 35% after deductible	100% of cost, 35% after deductible	
	Urgent care	\$90 copay /visit	\$50% coinsurance after deductible	

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

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 a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	35% coinsurance	50% coinsurance	50% coinsurance for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	50% coinsurance	None
	Inpatient services	35% coinsurance	50% coinsurance	
If you are pregnant	Office visits	\$70 copay /visit	100% coinsurance , 50% after deductible	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	35% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	35% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	35% coinsurance	50% coinsurance	60 visits/year
	Rehabilitation services	35% coinsurance	50% coinsurance	60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	35% coinsurance	50% coinsurance	
	Skilled nursing care	35% coinsurance	50% coinsurance	60 visits/calendar year
	Durable medical equipment	35% coinsurance	50% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	35% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Preventative	Not covered	Coverage limited to one exam/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.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care

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

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

- Infertility treatment outside the U.S.
- Private-duty nursing

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic care
- Weight loss programs
- Bariatric surgery
- Hearing aids

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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](#) **\$4,000**
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 35%
- Other [coinsurance](#) 35%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$500
Coinsurance	\$3,500
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$6,000

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) **\$4,000**
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 35%
- Other [coinsurance](#) 35%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles *	\$4,000
Copayments	\$1,210
Coinsurance	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$4,610

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) **\$4,000**
- [Specialist copayment](#) 70
- Hospital (facility) [coinsurance](#) 35%
- Other [coinsurance](#) 35%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles *	\$4,000
Copayments	\$250
Coinsurance	\$525
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,775

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: [insert].

*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.