




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 ? | \$500 / individual or \$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 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? | Yes. \$300 for prescription drug coverage and \$300 for occupational therapy services. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan ? | For network providers \$2,500 individual / \$5,000 family; for out-of-network providers \$4,000 individual / \$8,000 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 ? | 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. See [www.insert.com] or call 1-800-[insert] 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 ? | Yes. | 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 and 20% coinsurance for other outpatient services; deductible does not apply | 40% coinsurance | None |
| | Specialist visit | \$50 copay /visit | 40% coinsurance | 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 | 40% coinsurance | 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) | \$10 copay /test | 40% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | \$50 copay /test | 40% coinsurance | |
| 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) | \$10 copay /prescription (retail & mail order) | 40% coinsurance | Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). |
| | Preferred brand drugs (Tier 2) | \$30 copay /prescription (retail & mail order) | 40% coinsurance | |
| | Non-preferred brand drugs (Tier 3) | 40% coinsurance | 60% coinsurance | |
| | Specialty drugs (Tier 4) | 50% coinsurance | 70% coinsurance | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$100/day copay | 40% 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 | 20% coinsurance | 40% coinsurance | 50% coinsurance for anesthesia. |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 20% coinsurance | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | |
| | Urgent care | \$30 copay /visit | 40% coinsurance | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% 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. |

[* 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) | |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | 50% coinsurance for anesthesia. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$35 copay /office visit and 20% coinsurance for other outpatient services | 40% coinsurance | None |
| | Inpatient services | 20% coinsurance | 40% coinsurance | |
| If you are pregnant | Office visits | 20% coinsurance | 40% coinsurance | 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 | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | 60 visits/year |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | 60 visits/year. Includes physical therapy, speech therapy, and occupational therapy. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | 60 visits/calendar year |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. |
| | Hospice services | 20% 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 | \$35 copay /visit | Not covered | Coverage limited to one exam/year. |
| | Children's glasses | 20% coinsurance | Not covered | Coverage limited to one pair of glasses/year. |
| | Children's dental check-up | No charge | 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
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Weight loss programs

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].

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf [insert telephone number] uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni [insert telephone number].

Carolinian (Kapasal Falawasch): ngere aukke ghut allilis reel kapasal Falawasch au fafaingi tilfon ye [insert telephone number].

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang [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](#) \$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 \$12,700

In this example, Peg would pay:

Cost Sharing

| | |
|-----------------------------------|-----------------|
| Total Example Cost | \$12,700 |
| Deductibles | \$500 |
| Copayments | \$200 |
| Coinsurance | \$1,800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,560 |

- 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 \$5,600

In this example, Joe would pay:

| | |
|-----------------------------------|----------------|
| <i>Cost Sharing</i> | |
| Deductibles* | \$800 |
| Copayments | \$900 |
| Coinsurance | \$100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,820 |

- 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 | \$2,800 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles* | \$500 |

| | |
|-----------------------------|----------------|
| Total Example Cost | \$2,800 |
| Copayments | \$200 |
| Coinsurance | \$400 |
| <i>What isn't covered</i> | |

| | |
|-----------------------------------|----------------|
| Total Example Cost | \$2,800 |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,100 |

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.