
 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 call 1-855-375-7125 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">network and out-of-network providers</a> : \$1,750 Individual / \$3,500 Family Benefit Period: Per Plan year.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meet the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , Prescription Drug and Physician services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">network and out-of-network providers</a> : \$5,500 Individual / \$11,000 Family;	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">Preauthorization</a> , and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	No. It is an open access <a href="#">plan</a> . However, the plan does provide a physician network through the MultiPlan PHCS Practitioner and Ancillary Network. A list of <a href="#">network providers</a> can be found at <a href="http://www.multiplan.com">www.multiplan.com</a> or call 1-888.342.7427.	This <a href="#">plan</a> is an open access <a href="#">plan</a>
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see a <a href="#">specialist</a> you choose without a <a href="#">referral</a>

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">co-pay</a> / visit; <a href="#">deductible</a> doesn't apply	\$25 <a href="#">co-pay</a> / visit; <a href="#">deductible</a> doesn't apply	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">co-pay</a> / visit; <a href="#">deductible</a> doesn't apply	\$40 <a href="#">co-pay</a> / visit; <a href="#">deductible</a> doesn't apply	Chiropractic Care – Limit 25 visits per plan year
	<a href="#">Preventive care/screening</a> / immunization	No Charge	No Charge	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab / Blood Work: \$25 <a href="#">co-pay</a> ; <a href="#">deductible</a> doesn't apply X-Ray: \$40 <a href="#">co-pay</a> ; <a href="#">deductible</a> doesn't apply		None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		<a href="#">Preauthorization</a> is required
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at 877-226-2378.	Generic drugs	\$10 <a href="#">co-pay</a> Retail \$20 <a href="#">co-pay</a> Mail Order	Not Covered	All Tiers.
	Preferred brand drugs	\$50 <a href="#">co-pay</a> Retail \$100 <a href="#">co-pay</a> Mail Order	Not Covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Non-preferred brand drugs	\$75 <a href="#">co-pay</a> Retail \$150 <a href="#">co-pay</a> Mail Order	Not Covered	
	<a href="#">Specialty drugs</a>	\$100 <a href="#">co-pay</a> Retail \$200 <a href="#">co-pay</a> Mail Order	Not Covered	<a href="#">Deductible</a> waived for Rx.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		<a href="#">Preauthorization</a> is required
	Physician/surgeon fees	\$40 <a href="#">co-pay</a> / visit; <a href="#">deductible</a> doesn't apply	\$40 <a href="#">co-pay</a> / visit; <a href="#">deductible</a> doesn't apply	-----None-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$500 <a href="#">co-pay</a> ; <a href="#">deductible</a> doesn't apply		<a href="#">co-pay</a> is waived if admitted as inpatient from ER. All facilities are covered as in-network subject to meeting "emergency" criteria
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		None
	<a href="#">Urgent care</a>	\$40 <a href="#">co-pay</a> / visit; <a href="#">deductible</a> doesn't apply	\$40 <a href="#">co-pay</a> / visit; <a href="#">deductible</a> doesn't apply	None

[\* For more information about limitations and exceptions, contact 1-855-375-7125

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)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		<a href="#">Preauthorization</a> is required
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		<a href="#">Preauthorization</a> is required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <a href="#">co-pay</a> ; <a href="#">deductible</a> doesn't apply	\$50 <a href="#">co-pay</a> ; <a href="#">deductible</a> doesn't apply	<a href="#">Preauthorization</a> is required for intensive care outpatient service. Maximum 30 visits for ABA therapy per plan year.
	Inpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		<a href="#">Preauthorization</a> is required
If you are pregnant	Office visits	\$25 <a href="#">co-pay</a> / 1 <sup>st</sup> Visit; <a href="#">deductible</a> doesn't apply	\$25 <a href="#">co-pay</a> / 1 <sup>st</sup> Visit; <a href="#">deductible</a> doesn't apply	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		<a href="#">Preauthorization</a> is required
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$40 <a href="#">co-pay</a> / Visit; <a href="#">deductible</a> doesn't apply	\$40 <a href="#">co-pay</a> / Visit; <a href="#">deductible</a> doesn't apply	<a href="#">Preauthorization</a> is required. Maximum 60 visits per plan year
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">co-pay</a> / Visit; <a href="#">deductible</a> doesn't apply	\$40 <a href="#">co-pay</a> / Visit; <a href="#">deductible</a> doesn't apply	<a href="#">Preauthorization</a> is required. Maximum 30 visits per therapy per plan year. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	\$40 <a href="#">co-pay</a> / Visit; <a href="#">deductible</a> doesn't apply	\$40 <a href="#">co-pay</a> / Visit; <a href="#">deductible</a> doesn't apply	<a href="#">Preauthorization</a> is required. Maximum 30 visits per plan year
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		<a href="#">Preauthorization</a> is required. 60 day maximum per plan year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		<a href="#">Preauthorization</a> is required
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		<a href="#">Preauthorization</a> is required
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

[\* For more information about limitations and exceptions, contact 1-855-375-7125

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
• Acupuncture	• Bariatric Surgery	• Cosmetic Surgery
• Hearing Aids	• Long-Term Care	• Non-Emergency Care outside US
• Routine Dental Care	• Routine Eye Care	• Routine Foot Care
• Weight Loss Programs	•	•
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
• Chiropractic Care	• Infertility Services (Basic)	•

**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: 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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](http://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: 1-855-375-7125.

### 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 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 1-855-375-7125

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-375-7125.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-375-7125.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-375-7125.

————— *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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist co-pay</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">co-insurance</a>	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*)

<b>Total Example Cost</b>	<b>\$13,540</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,750
Copayments	\$250
Coinsurance	\$1,875
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,875</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist co-pay</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">co-insurance</a>	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*)

<b>Total Example Cost</b>	<b>\$4,110</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,750
Copayments	\$300
Coinsurance	\$125
<i>What isn't covered</i>	
Limits or exclusions	\$290
<b>The total Joe would pay is</b>	<b>\$2,470</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist co-pay</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">co-insurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,400</b>