



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 <https://www.healthcare.gov/sbc-glossary/> or call **866-826-5317** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	No Deductible	You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b><u>deductible</u></b>
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	
Are there other <a href="#">deductibles</a> for specific services?	No	The <b><u>out-of-pocket limit</u></b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for your health care expenses
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	There is no out-of-pocket limit for the plan	
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, Prior Authorization Penalties, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <b><u>out-of-pocket limit</u></b> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, when utilizing a network provider, a discount is applied.	There are no benefits for out-of-network services
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	Has to be an in-network specialist for the service to be covered by the plan

 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 office</a> or clinic	Primary care visit to treat an injury or illness	\$20 Copay/visit	Not Covered	Max 3 visits per calendar year
	<a href="#">Specialist</a> visit	\$50 Copay/visit	Not Covered	Max 3 visits per calendar year
	<a href="#">Preventive care/screening/immunization</a>	No Charge, 100% covered	Not Covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 copay/service	Not Covered	Max 5 services per calendar year
	Imaging (CT/PET scans, MRIs)	\$200 Copay	Not Covered	Max 1 MRI or CT Scan per calendar year
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.[insert].com</a>	Tier 1: Low Cost Generics	\$1 Copay/per script	Not Covered	
	Tier 2: Generics	10% Coinsurance	Not Covered	
	Tier 3: Preferred brand	20% Coinsurance	Not Covered	
	Tier 4: Non-Preferred Brand	40% Coinsurance	Not Covered	
	Tier 5: Generic and Preferred Specialty Drugs	10% Coinsurance	Not Covered	Plan pays 90% up to a maximum of \$150 per Rx
	Tier 6: Non-Preferred Specialty Drugs	20% Coinsurance	Not Covered	Plan pays 80% up to a maximum of \$250 per Rx
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance up to \$5,000, maximum payable benefit \$2,500. If service rendered in ambulatory surgery center it must be affiliated with a network hospital	Not Covered	Maximum Benefit for all Inpatient/Outpatient, ER, hospital related services, 50% coinsurance to \$5,000. Max total benefit, \$2,500
	Physician/surgeon fees		Not Covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>		Not Covered	
	<a href="#">Emergency medical transportation</a>		Not Covered	
	<a href="#">Urgent care</a>	\$50 Copay/visit	Not Covered	Max 3 visits per calendar year

\* For more information about limitations and exceptions, see the plan or policy document.

<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	50% Coinsurance up to \$5,000, maximum payable benefit \$2,500	Not Covered	Maximum Benefit for all Inpatient/Outpatient, ER, hospital related services, 50% coinsurance to \$5,000. Max total benefit, \$2,500
	Physician/surgeon fees		Not Covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Not Covered	Not Covered	
	Inpatient services	Not Covered	Not Covered	
<b>If you are pregnant</b>	Office visits	Not Covered	Not Covered	
	Childbirth/delivery professional services	50% Coinsurance up to \$5,000, maximum payable benefit \$2,500	Not Covered	Maximum Benefit for all Inpatient/Outpatient, ER, hospital related services, 50% coinsurance to \$5,000. Max total benefit, \$2,500
	Childbirth/delivery facility services		Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not Covered	Not Covered	
	<a href="#">Rehabilitation services</a>	Not Covered	Not Covered	
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	
	<a href="#">Skilled nursing care</a>	Not Covered	Not Covered	
	<a href="#">Durable medical equipment</a>	Not Covered	Not Covered	
	<a href="#">Hospice services</a>	Not Covered	Not Covered	
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	No Charge	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	No Charge	No Charge	

### 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](#).)

- |                        |                    |                      |
|------------------------|--------------------|----------------------|
| • Contrast or 3-D MRIs | • PET Scans        | • Radiation Oncology |
| • Chemotherapy         | • Therapy Services | • Chiropractic Care  |

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

- |            |                  |                   |
|------------|------------------|-------------------|
| • Hospital | • Emergency Room | • Specialty Drugs |
|------------|------------------|-------------------|

\* For more information about limitations and exceptions, see the plan or policy document.

**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](http://www.HealthCare.gov) or call **866-826-5317**

**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 the 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 [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].]

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*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](#) **N/A**
- [Specialist](#) [*\$50 Copayments*] **\$150**
- Hospital (facility) [*coinsurance*] **50%**
- Other [*Lab Services, Copayment*] **\$50**
- Other [*Preferred Brand Drugs, 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*)

<b>Total Example Cost</b>	<b>\$10,200</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	N/A
Copayments	\$250
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$5,200
<b>The total Peg would pay is</b>	<b>\$6,950</b>

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

- The [plan's](#) overall [deductible](#) **N/A**
- [Specialist](#) [*copayments*] **\$50**
- Hospital (facility) [*coinsurance*] **50%**
- Other [*Lab Services, Copayment*] **\$50**
- Prescription Drugs, [*Non-Preferred Brand Drugs, Coinsurance*] **40%**

**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>\$2,800</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	N/A
Copayments	\$300
Coinsurance	\$560
<i>What isn't covered</i>	
Limits or exclusions	\$65
<b>The total Joe would pay is</b>	<b>\$925</b>

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

- The [plan's](#) overall [deductible](#) **N/A**
- [Specialist](#) [*copayments*] **\$50**
- Hospital (facility) [*coinsurance*] **50%**
- Other [*X-ray Services, Copayment*] **\$50**
- Prescription Drugs, [*Generic, Coinsurance*] **10%**

**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>\$2,950</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	N/A
Copayments	\$150
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$825
<b>The total Mia would pay is</b>	<b>\$1,475</b>