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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$8,000/individual or $16,000/family	Generally, you must pay all 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.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	$8,000/individual or $16,000 /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?	Premiums, balanced-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?	No network restrictions.	
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% after deductible	Subject to plan allowable
	Specialist visit	0% after deductible	Subject to plan allowable
	Preventive care/screening/ immunization	0% coinsurance	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. Subject to plan allowable
	Chiropractic Visit	0% after deductible	Limited to 15 visits per benefit period; Includes x-rays
If you have a test	Diagnostic test (blood work)	0% after deductible	Subject to plan allowable
	Imaging (X-Ray, CT/PET scans, MRIs)	Facility: 0% after deductible Professional Fees: 0% after deductible	Subject to plan allowable
If you need drugs to treat your illness or condition	Generic drugs	0% after deductible	Copays listed are for 0-90 day supply/prescription. Copays apply to Retail and/or Mail Order.
	Preferred brand drugs	0% after deductible	
	Non-preferred brand drugs	0% after deductible	
	Specialty drugs	Excluded	Excluded
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% after deductible	Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum). Subject to plan allowable.
	Physician/surgeon fees	0% after deductible	Subject to plan allowable
If you need immediate medical attention	Emergency room care	Facility: 0% after deductible Professional Fees: 0% after deductible	Subject to plan allowable
	Emergency medical transportation	0% after deductible	Subject to plan allowable
	Urgent care	0% after deductible	Subject to plan allowable
If you have a hospital stay	Facility fee (e.g., hospital room)	Facility: 0% after deductible	Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum). Subject to plan allowable.
	Physician/surgeon fees	Professional Fees: 0% after deductible	Subject to plan allowable

Common Medical Event	Services You May Need	Member out of pocket	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health and substance abuse services	Outpatient services	0% after deductible	Subject to plan allowable
	Inpatient services	0% after deductible	Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum). Subject to plan allowable.
If you are pregnant	Office visits	Professional Fees: 0% after deductible	Subject to plan allowable
	Childbirth/delivery professional services	Professional Fees: 0% after deductible	Subject to plan allowable
	Childbirth/delivery facility services	Facility: 0% after deductible	Subject to plan allowable
If you need help recovering or have other special health needs	Home health care	0% after deductible	Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum). Subject to plan allowable.
	Rehabilitation services	0% after deductible	Limited to 20 visits combined for Occupational, Physical and Speech therapies, per calendar year. Cardiac Rehabilitation therapy is limited to 20 visits per calendar year. Chiropractic services are limited to 15 visits per calendar year. Subject to plan allowable
	Habilitation services	0% after deductible	Limited to 20 visits per Calendar Year, combined with the above therapies. Subject to plan allowable
	Skilled nursing care	0% after deductible	Limited to 60 days per Calendar Year. Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum). Subject to plan allowable
	Durable medical equipment	0% after deductible	Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum). Subject to plan allowable.
	Hospice services	0% after deductible	Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum). Subject to plan allowable.
If your child needs dental or eye care	Children's eye exam	Not covered	None
	Children's glasses	Not covered	None
	Children's dental check-up	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility treatments
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 plan document.)

- Chiropractic Care
- Durable medical equipment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends.

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.

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.

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 pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$8,000**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	
Deductibles	$8,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$8,000**

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

- **The plan's overall deductible** **$8,000**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	**$8,000**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$8,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$8,000**

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

- **The plan's overall deductible** **$8,000**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	**$500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$8,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

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