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?	For **Network providers** $6,000/individual or $12,000/family; for **Non-network providers** $12,000/individual or $24,000 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**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	For **Network providers** $9,450 individual / $18,900 family; for **Non-network providers** $18,900/individual or $37,900/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?	Yes.	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?	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	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	$30 copay/visit	Deductible, 60% coinsurance subject to Plan's allowable fee	None
	Specialist visit	$60 copay/visit	Deductible, 60% coinsurance subject to Plan's allowable fee	None
	Chiropractic Care	$30 copay/visit		Subject to plan allowable
	Preventive care/screening/ immunization	No Charge	Deductible, 60% coinsurance subject to Plan's allowable fee	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.
If you have a test	Diagnostic test (blood work)	$30 copay/visit	Deductible, 60% coinsurance subject to Plan's allowable fee	Subject to plan allowable
	Imaging (X-Ray, CT/PET scans, MRIs)	Facility: 30% of plan allowable, deductible does not apply Professional Fees: 30% after deductible	Deductible, 60% coinsurance subject to Plan's allowable fee	Subject to plan allowable
If you need drugs to treat your illness or condition More information about **prescription drug coverage**	Generic drugs	$15 copay/prescription	Not covered	Copays listed are for 0-30 day supply/prescription. 31-90 day supply; generic $45.00, brand name $90.00, Non-Preferred Brand $150.00 Copays apply to Retail and/or Mail Order.
	Preferred brand drugs	$65 copay/prescription	Not covered	
	Non-preferred brand drugs	$100 copay/prescription	Not covered	
	Specialty drugs	Excluded	Excluded	Excluded
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Facility: 30% of plan allowable, deductible does not apply	Deductible, 60% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum).
	Physician/surgeon fees	Professional Fees: 30% after deductible, subject to plan allowable	Deductible, 60% coinsurance subject to Plan's allowable fee	None

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 need immediate medical attention	Emergency room care	Facility: 30% of plan allowable, deductible does not apply Professional Fees: 30% after deductible	20% after deductible	Out of network is subject to plan allowable fee.
	Emergency medical transportation	30% after deductible	Deductible, 60% coinsurance	Subject to plan allowable fee
	Urgent care	$60 copay/visit	Deductible, 60% coinsurance	Subject to plan allowable fee
If you have a hospital stay	Facility fee (e.g., hospital room)	Facility: 30% of plan allowable, deductible does not apply	Deductible, 60% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum).
	Physician/surgeon fees	Professional Fees: 30% after deductible	Deductible, 60% coinsurance subject to Plan's allowable fee	None
If you need mental health, behavioral health and substance abuse services	Outpatient services	$30 copay/visit	Deductible, 60% coinsurance subject to Plan's allowable fee	None
	Inpatient services	Deductible/Coinsurance	Deductible, 60% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($500 maximum).
If you are pregnant	Office visits	Professional Fees: 30% after deductible	Deductible, 60% coinsurance subject to Plan's allowable fee	None
	Childbirth/delivery professional services	Professional Fees: 30% after deductible	Deductible, 60% coinsurance subject to Plan's allowable fee	None
	Childbirth/delivery facility services	20% after deductible	Deductible, 60% coinsurance subject to Plan's allowable fee	None
If you need help recovering or have other special health needs	Home health care	30% after deductible	Deductible, 60% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum).
	Rehabilitation services	0% after copayment, per visit	Deductible, 60% coinsurance subject to Plan's allowable fee	Limited to 20 visits combined for Occupational, Physical and Speech therapies, per calendar year. Cardiac

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)	
	Habilitation services	0% after copayment, per visit	Deductible, 60% coinsurance subject to Plan's allowable fee	Rehabilitation therapy is limited to 20 visits per calendar year. Chiropractic services are limited to 15 visits per calendar year.
	Skilled nursing care	Facility: 30% of plan allowable, deductible does not apply Professional Fees: 30% after deductible	Deductible, 60% coinsurance subject to Plan's allowable fee	Limited to 90 days per Calendar Year. Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum).
	Durable medical equipment	30% after deductible	Deductible, 60% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum).
	Hospice services	30% after deductible	Deductible, 60% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction ($10,000 maximum).
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	None
	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.)

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

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 in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$6,000**
- **Specialist *[copayment]*** **$60**
- **Hospital (facility) *[coinsurance]*** **30%**
- **Other *[coinsurance]*** **30%**

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	$6,000
Copayments	$60
Coinsurance	$1,992
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$8,052**

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

- **The plan's overall deductible** **$6,000**
- **Specialist *[copayment]*** **$60**
- **Hospital (facility) *[coinsurance]*** **30%**
- **Other *[coinsurance]*** **30%**

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	$6,000
Copayments	$170
Coinsurance	$549
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$6,719**

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

- **The plan's overall deductible** **$6,000**
- **Specialist *[copayment]*** **$60**
- **Hospital (facility) *[coinsurance]*** **30%**
- **Other *[coinsurance]*** **30%**

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	$6,000
Copayments	$100
Coinsurance	$120
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$220**

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