 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 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 <a href="#">deductible</a> ?	\$	
Are there services covered before you meet your <a href="#">deductible</a> ?		
Are there other <a href="#">deductibles</a> for specific services?	\$	
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$	
What is not included in the <a href="#">out-of-pocket limit</a> ?		
Will you pay less if you use a <a href="#">network provider</a> ?		
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</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			
	<a href="#">Specialist</a> visit			
	<a href="#">Preventive care/screening/immunization</a>			
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
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>	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
	<a href="#">Specialty drugs</a>			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
If you need immediate medical attention	<a href="#">Emergency room care</a>			
	<a href="#">Emergency medical transportation</a>			
	<a href="#">Urgent care</a>			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services			
	Inpatient services			
If you are pregnant	Office visits			
	Childbirth/delivery professional services			

[\* 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)	
If you are pregnant	Childbirth/delivery facility services			
If you need help recovering or have other special needs	<a href="#">Home health care</a>			
	<a href="#">Rehabilitation services</a>			
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing center</a>			
	<a href="#">Durable medical equipment</a>			
If your child needs dental or eye care	<a href="#">Hospice services</a>			
	Children's eye exam			
	Children's glasses			
	Children's dental checkups			

### 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> .)		
•	•	•
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> 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 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/No]**

[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/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](#).

[\* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

## 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].]

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## PRA Disclosure Statement


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[\* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

## 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](#) \$
- [Specialist](#) [cost sharing] \$
- Hospital (facility) [cost sharing] %
- Other [cost sharing] %

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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$
Coinsurance	\$

<i>What isn't covered</i>	
Limits or exclusions	\$

The total Peg would pay is	\$
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### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$
- [Specialist](#) [cost sharing] \$
- Hospital (facility) [cost sharing] %
- Other [cost sharing] %

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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$
Coinsurance	\$

<i>What isn't covered</i>	
Limits or exclusions	\$

The total Joe would pay is	\$
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### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$
- [Specialist](#) [cost sharing] \$
- Hospital (facility) [cost sharing] %
- Other [cost sharing] %

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

<i>Cost Sharing</i>	
Deductibles	\$
Copayments	\$
Coinsurance	\$

<i>What isn't covered</i>	
Limits or exclusions	\$

The total Mia would pay is	\$
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[The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.]