**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 deductible?** | $ | |
| **Are there services covered before you meet your deductible?** | | |
| **Are there other deductibles for specific services?** | $ | |
| **What is the out-of-pocket limit for this plan?** | $ | |
| **What is not included in the out-of-pocket limit?** | | |
| **Will you pay less if you use a network provider?** | | |
| **Do you need a referral to see a specialist?** | | |

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(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

All and costs shown in this chart are after your has been met, if a applies.

| Common Medical Event | Services You May Need | What You Will Pay: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | 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 | | | |
| | Specialist visit | | | |
| | Preventive care/screening/ immunization | | | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | | | |
| | Imaging (CT/PET scans, MRIs) | | | |
| **If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www. [insert].com** | Generic drugs | | | |
| | Preferred brand drugs | | | |
| | Non-preferred brand drugs | | | |
| | Specialty drugs | | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | | | |
| | Physician/surgeon fees | | | |
| **If you need immediate medical attention** | Emergency room care | | | |
| | Emergency medical transportation | | | |
| | Urgent care | | | |
| **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 | | | |

[* 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: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you are pregnant** | Childbirth/delivery professional services | | | |
| | Childbirth/delivery facility services | | | |
| **If you need help recovering or have other special needs** | Home health care | | | |
| | Rehabilitation services | | | |
| | Habilitation services | | | |
| | Skilled nursing care | | | |
| | Durable medical equipment | | | |
| | Hospice services | | | |
| **If your child needs dental or eye care** | Children's eye exam | | | |
| | Children's glasses | | | |
| | Children's dental checkups | | | |

## 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.) | | |
|---|---|---|
| • | • | • |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan 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 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/Not Applicable]**
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, kwiijigo holne' [insert telephone number].]

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

[* 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 might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your charge, and many other factors. Focus on the amounts ( and ) and under the  Use this information to compare the portion of costs you might pay under different health . 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*)

**~~Total Example Cost~~$12,700**

**In this example, Peg would pay:**

| ~~*Cost Sharing*~~ | |
|---|---|
| Deductibles | $ |
| Copayments | $ |
| Coinsurance | $ |
| ~~*What isn't covered*~~ | |
| Limits or exclusions | $ |
| **~~The total Peg would pay is~~$** | |

### 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*)

**~~Total Example Cost~~$5,600**

**In this example, Joe would pay:**

| ~~*Cost Sharing*~~ | |
|---|---|
| Deductibles | $ |
| Copayments | $ |
| Coinsurance | $ |
| ~~*What isn't covered*~~ | |
| Limits or exclusions | $ |
| **~~The total Joe would pay is~~$** | |

### 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*)

**~~Total Example Cost~~$2,800**

**In this example, Mia would pay:**

| ~~*Cost Sharing*~~ | |
|---|---|
| Deductibles | $ |
| Copayments | $ |
| Coinsurance | $ |
| ~~*What isn't covered*~~ | |
| Limits or exclusions | $ |
| **~~The total Mia would pay is~~$** | |

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