# **Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services Coverage Period: 01/01/2025 – 12/31/2025

**Insurance Company 1: Plan Option 1 Coverage for: Family | Plan Type: PPO**

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**The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan.**](https://www.healthcare.gov/sbc-glossary/#plan) **The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) [balance billing,](https://www.healthcare.gov/sbc-glossary/#balance-billing) [coinsurance,](https://www.healthcare.gov/sbc-glossary/#coinsurance) [copayment,](https://www.healthcare.gov/sbc-glossary/#copayment) [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider,](https://www.healthcare.gov/sbc-glossary/#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**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | $500 / individual or $1,000 / family | Generally, you must pay all of the costs from [providers](https://www.healthcare.gov/sbc-glossary/#provider) up to the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan) begins to pay. If you have other family members on the [plan,](https://www.healthcare.gov/sbc-glossary/#plan) each family member must meet their own individual [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) until the total amount of [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) expenses paid by all family members meets the overall family [deductible.](https://www.healthcare.gov/sbc-glossary/#deductible) |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | Yes. [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care) and primary care services are covered before you meet your [deductible.](https://www.healthcare.gov/sbc-glossary/#deductible) | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers some items and services even if you haven’t yet met the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount. But a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. For example, this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers certain [preventive](https://www.healthcare.gov/sbc-glossary/#preventive-care) [services](https://www.healthcare.gov/sbc-glossary/#preventive-care) without [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) and before you meet your [deductible.](https://www.healthcare.gov/sbc-glossary/#deductible) See a list of covered [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) at [https://www.healthcare.gov/coverage/preventive-care-benefits/.](https://www.healthcare.gov/coverage/preventive-care-benefits/) |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | Yes. $300 for [prescription drug](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) [coverage](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) and $300 for occupational therapy services. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan) begins to pay for these services. |
| **What is the** [**out-of-pocket**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) [**limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | For [network providers](https://www.healthcare.gov/sbc-glossary/#network-provider) $2,500 individual / $5,000 family; for [out-](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) providers $4,000 individual / $8,000 family | The [out-of-pocket limit i](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)s the most you could pay in a year for covered services. If you have other family members in this [plan,](https://www.healthcare.gov/sbc-glossary/#plan) they have to meet their own [out-of-pocket limits](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) until the overall family [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) has been met. |
| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) for certain services, [premiums,](https://www.healthcare.gov/sbc-glossary/#premium) [balance-billing](https://www.healthcare.gov/sbc-glossary/#balance-billing) charges, and health care this [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t cover. | Even though you pay these expenses, they don’t count toward the [out-of-pocket limit.](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. See [www.insert.com] or call 1-800-[insert] for a list of [network](https://www.healthcare.gov/sbc-glossary/#network-provider)  [providers.](https://www.healthcare.gov/sbc-glossary/#network-provider) | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) uses a [provider](https://www.healthcare.gov/sbc-glossary/#provider) [network.](https://www.healthcare.gov/sbc-glossary/#network) You will pay less if you use a [provider](https://www.healthcare.gov/sbc-glossary/#provider) in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) [network.](https://www.healthcare.gov/sbc-glossary/#network) You will pay the most if you use an [out-of-network provider,](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) and you might receive a bill from a [provider](https://www.healthcare.gov/sbc-glossary/#provider) for the difference between the [provider’s](https://www.healthcare.gov/sbc-glossary/#provider) charge and what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) pays [(balance](https://www.healthcare.gov/sbc-glossary/#balance-billing) [billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). Be aware, your [network provider](https://www.healthcare.gov/sbc-glossary/#network-provider) might use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) for some services (such as lab work). Check with your [provider](https://www.healthcare.gov/sbc-glossary/#provider) before you get services. |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | Yes. | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay some or all of the costs to see a [specialist](https://www.healthcare.gov/sbc-glossary/#specialist) for covered services but only if you have a [referral](https://www.healthcare.gov/sbc-glossary/#referral) before you see the [specialist.](https://www.healthcare.gov/sbc-glossary/#specialist) |

Exclamation point to label important information

All [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment)and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance)costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#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** [**provider’s**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | $35 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/office visit and 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) for other outpatient services; [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | $50 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)visit | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If you don't get [preauthorization,](https://www.healthcare.gov/sbc-glossary/#preauthorization) benefits could be reduced by 50% of the total cost of the service. |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)[/screening/](https://www.healthcare.gov/sbc-glossary/#screening) immunization | No charge | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | You may have to pay for services that aren’t preventive. Ask your [provider](https://www.healthcare.gov/sbc-glossary/#provider) if the services needed are preventive. Then check what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay for. |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | $10 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/test | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None |
| Imaging (CT/PET scans, MRIs) | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/test | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you need drugs to treat your illness or condition** More information about [**prescription drug**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage)[**coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage)is available at [www.insert.com] | Generic drugs (Tier 1) | $10 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)prescription (retail & mail order) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). |
| Preferred brand drugs (Tier 2) | $30 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)prescription (retail & mail order) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| Non-preferred brand drugs (Tier 3) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 60% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) (Tier 4) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 70% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $100/day [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If you don't get [preauthorization,](https://www.healthcare.gov/sbc-glossary/#preauthorization) benefits could be reduced by 50% of the total cost of the service. |
| Physician/surgeon fees | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) for anesthesia. |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None |
| [Emergency medical](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) [transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | $30 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)visit | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If you don't get [preauthorization,](https://www.healthcare.gov/sbc-glossary/#preauthorization) benefits could be reduced by 50% of the total cost of the service. |
| Physician/surgeon fees | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) for anesthesia. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $35 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/office visit and 20% [coinsuranc](https://www.healthcare.gov/sbc-glossary/#coinsurance)e for other outpatient services | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None |
| Inpatient services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you are pregnant** | Office visits | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) does not apply for [preventive](https://www.healthcare.gov/sbc-glossary/#preventive-care) [services.](https://www.healthcare.gov/sbc-glossary/#preventive-care) Depending on the type of services, a [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| Childbirth/delivery professional services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| Childbirth/delivery facility services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 60 visits/year |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 60 visits/year. Includes physical therapy, speech therapy, and occupational therapy. |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 60 visits/calendar year |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If you don't get [preauthorization,](https://www.healthcare.gov/sbc-glossary/#preauthorization) benefits could be reduced by 50% of the total cost of the service. |
| **If your child needs dental or eye care** | Children’s eye exam | $35 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)visit | Not covered | Coverage limited to one exam/year. |
| Children’s glasses | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Not covered | Coverage limited to one pair of glasses/year. |
| Children’s dental check-up | No charge | Not covered | None |

## Excluded Services & Other Covered Services:

|  |  |  |
| --- | --- | --- |
| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | |
| * Cosmetic surgery * Dental care (Adult) * Infertility treatment | * Long-term care * Non-emergency care when traveling outside the U.S. * Private-duty nursing | * Routine eye care (Adult) * Routine foot care |

|  |  |  |
| --- | --- | --- |
| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** | | |
| * Acupuncture (if prescribed for rehabilitation purposes) * Bariatric surgery | * Chiropractic care * Hearing aids | * Weight loss programs |

**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](https://www.healthcare.gov/sbc-glossary/#health-insurance) [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace) For more information about the [Marketplace,](https://www.healthcare.gov/sbc-glossary/#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 f](https://www.healthcare.gov/sbc-glossary/#plan)or a denial of a [claim.](https://www.healthcare.gov/sbc-glossary/#claim) This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal.](https://www.healthcare.gov/sbc-glossary/#appeal) For more information about your rights, look at the explanation of benefits you will receive for that medical [claim.](https://www.healthcare.gov/sbc-glossary/#claim) Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information on how to submit a [claim,](https://www.healthcare.gov/sbc-glossary/#claim) [appeal,](https://www.healthcare.gov/sbc-glossary/#appeal) or a [grievance f](https://www.healthcare.gov/sbc-glossary/#grievance)or any reason to your [plan.](https://www.healthcare.gov/sbc-glossary/#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.**

[Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) generally includes [plans,](https://www.healthcare.gov/sbc-glossary/#plan) [health insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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,](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) you may not be eligible for the [premium tax credit.](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits)

**Does this plan meet the Minimum Value Standards? Yes.**

If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards,](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard) you may be eligible for a [premium tax credit t](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits)o help you pay for a [plan t](https://www.healthcare.gov/sbc-glossary/#plan)hrough the [Marketplace.](https://www.healthcare.gov/sbc-glossary/#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, kwiijigo holne' [insert telephone number].

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf [insert telephone number] uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala’au mai i le numera telefoni [insert telephone number].

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye [insert telephone number].

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å’gang [insert telephone number].

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***To see examples of how this*** [***plan***](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost-sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles,](https://www.healthcare.gov/sbc-glossary/#deductible) [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan.](https://www.healthcare.gov/sbc-glossary/#plan) Use this information to compare the portion of costs you might pay under different health [plans.](https://www.healthcare.gov/sbc-glossary/#plan) 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**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$500**
* [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **$50**
* **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **20%**
* **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **20%**

**This EXAMPLE event includes services like:**

[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) office visits *(prenatal care)*

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(ultrasounds and blood work)*

[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
| --- | --- |
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $500 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $200 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $1,800 |
| *What isn’t covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,560** |

**Managing Joe’s Type 2 Diabetes**

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

* **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$500**
* [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **$50**
* **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **20%**
* **Other [coinsurance](https://www.healthcare.gov/sbc-glossary/" \l "coinsurance) 20%**

**This EXAMPLE event includes services like:**

[Primary care physician](https://www.healthcare.gov/sbc-glossary/#primary-care-physician) office visits *(including disease education)*

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(blood work)*

[Prescription drugs](https://www.healthcare.gov/sbc-glossary/#prescription-drugs)

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(glucose meter)*

| **Total Example Cost** | **$5,600** |
| --- | --- |
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible)\* | $800 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $900 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $100 |
| *What isn’t covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,820** |

**Mia’s Simple Fracture**

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

* **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$500**
* [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **$50**
* **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **20%**
* **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **20%**

**This EXAMPLE event includes services like:**

[Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) *(including medical supplies)*

[Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (*x-ray*)

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(crutches)*

[Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) *(physical therapy)*

| **Total Example Cost** | **$2,800** |
| --- | --- |
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible)\* | $500 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $200 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $400 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,100** |

Note: These numbers assume the patient does not participate in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) wellness program. If you participate in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].

\*Note: This [plan](https://www.healthcare.gov/sbc-glossary/#plan) has other [deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) for specific services included in this coverage example. See "Are there other [deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) for specific services?” row above.

The [plan](https://www.healthcare.gov/sbc-glossary/#plan) would be responsible for the other costs of these EXAMPLE covered services.