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 general 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.healthcare.gov/sbc-glossary.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	None	Generally, you must pay all of 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?	Not Applicable	This Plan has no deductible
Are there other deductibles for specific services?	Not Applicable	This Plan has no deductible
What is the out-of-pocket limit for this plan?	**Prescription Drug** $3,600 individual / $7,200 family Per Calendar Year	The out-of-pocket limit is the most you could pay during the plan 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, medical care services or prescriptions 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	There are no out-of-network benefits or coverage.
Do you need a referral to see a specialist?	Not Applicable	Must enroll in separate Medical plan for medical benefits.

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 provider's office or clinic	Primary care visit to treat an injury or illness	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Specialist visit	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Preventive care/screening/ immunization	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	**Retail or ECH Pharmacy:** $5/prescription **Mail Order:** $10/prescription	Not Covered	Retail: Up to 30-day supply Mail Order or ECH Outpatient Pharmacy: Up to 90-day supply
	Preferred brand drugs	**Retail or ECH Pharmacy:** $20/prescription **Mail Order:** $40/prescription	Not Covered	
	Non-preferred brand drugs	**Retail or ECH Pharmacy:** $20/prescription **Mail Order:** $40/prescription	Not Covered	
	Specialty drugs	**Retail or ECH Pharmacy:** $20/prescription **Mail Order:** $40/prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Physician/surgeon fees	Not Covered	Not Covered	Must enroll in separate Medical plan for

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)	
				medical benefits.
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Emergency medical transportation	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Urgent care	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Physician/surgeon fees	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Inpatient services	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
If you are pregnant	Office visits	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Childbirth/delivery professional services	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Childbirth/delivery facility services	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Rehabilitation services	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Habilitation services	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Skilled nursing care	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
	Durable medical equipment	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.

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)	
	Hospice services	Not Covered	Not Covered	Must enroll in separate Medical plan for medical benefits.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Must enroll in separate Vision plan for vision benefits.
	Children's glasses	Not Covered	Not Covered	Must enroll in separate Vision plan for vision benefits.
	Children's dental check-up	Not Covered	Not Covered	Must enroll in separate Dental plan for dental benefits.

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.)

- All medical, dental and vision services are excluded from this plan. You must enroll in separate medical, dental and vision plans for coverage

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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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: OptumRx at (844) 813-7269.

Does this plan provide Minimum Essential Coverage? **Yes**
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**
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	**N/A**
Specialist	**N/A**
Hospital (facility)	**N/A**
Other	**N/A**

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	**$**
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	**N/A**
Specialist	**N/A**
Hospital (facility)	**N/A**
Other	**N/A**

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	**$**
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	**N/A**
Specialist	**N/A**
Hospital (facility)	**N/A**
Other	**N/A**

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	**$**
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.