



**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, 1-866-815-6001. 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.ccio.cms.gov](http://www.ccio.cms.gov).

| Important Questions                                                             | In- Network                                                                                              |                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Plan Name                                                                       | Max Guard 300                                                                                            |                   | The Plan Name identifies the specific plan type and its associated benefits, coverage, and cost-sharing arrangements.                                                                                                                                                                                                                                                                                                              |
| What is the overall <a href="#">deductible</a> ?                                | Individual:<br>\$ 300                                                                                    | Family:<br>\$ 600 | This is the amount you must pay out-of-pocket for covered services before your benefit plan starts to contribute to the costs.                                                                                                                                                                                                                                                                                                     |
| Plan Type                                                                       | EPO Limited Medical                                                                                      |                   | A health plan type defines the structure of how your health insurance works, including how you access care, what costs are covered, and how much you pay out-of-pocket.                                                                                                                                                                                                                                                            |
| Network                                                                         | First Health                                                                                             |                   | The network refers to a group of healthcare providers, such as doctors, hospitals, and pharmacies, that have contracted with the plan to provide services at discounted rates to the company's members.                                                                                                                                                                                                                            |
| Pharmacy Benefit Manager                                                        | Ventegra                                                                                                 |                   | Pharmacy Benefit Manager (PBM) is a company that manages prescription drug benefits for health insurers, employers, and other payers.                                                                                                                                                                                                                                                                                              |
| Telemedicine Platform / Services                                                | MyLiveDoc                                                                                                |                   | A telemedicine platform is a technology system that facilitates remote medical consultations, typically through video conferencing, while ensuring patient privacy, security, and data compliance.                                                                                                                                                                                                                                 |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Preventive care services, office visits, & urgent care are covered before you meet your deductible. |                   | This plan covers some items and services even if you haven't met your deductible. 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> |
| Are there other <a href="#">deductibles</a> for specific services?              | No                                                                                                       |                   | You do not have to meet your deductible for specific services.                                                                                                                                                                                                                                                                                                                                                                     |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Individual:<br>\$ 0                                                                                      | Family:<br>\$ 0   | An out-of-pocket maximum in health insurance is the maximum amount you'll pay for covered healthcare services in a plan year.                                                                                                                                                                                                                                                                                                      |
| Maximum Annual Benefit Amount per Household                                     | \$0                                                                                                      |                   | The total dollar amount that a health plan will pay for covered services for all members of a household during a plan year.                                                                                                                                                                                                                                                                                                        |
| Maximum Lifetime Benefit Amount per Household                                   | \$0                                                                                                      |                   | The total dollar amount that a plan will pay for covered medical expenses for all members of a household over the entire lifetime of the policy. Once this cap is reached, the plan is no longer responsible for paying any further benefits for any covered individuals in that household, regardless of the medical need.                                                                                                        |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Premiums, pre-certification penalties, balance billed charges, & health care this plan does not cover.   |                   | Even though you pay these out-of-pocket expenses, they do not count toward the out-of-pocket limit.                                                                                                                                                                                                                                                                                                                                |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes                                                                                                      |                   | If you use an in-network provider, you will pay less. If you use an out-of-network provider, you will pay more.                                                                                                                                                                                                                                                                                                                    |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No                                                                                                       |                   | A referral to a specialist is a recommendation or direction from a primary care physician (PCP) or another healthcare provider to see a specialist who has expertise in a specific area of medicine.                                                                                                                                                                                                                               |

 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) |                                                                                                                                                                                                                                                              |
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness                                                                                                                            | \$50 Copayment after Deductible           | Not Covered                                     | 10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits, Mental Health Only Therapy office visits.                                                                                                                 |
|                                                               | <a href="#">Specialist</a> visit                                                                                                                                            | \$50 Copayment after Deductible           | Not Covered                                     | 10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits, Mental Health Only Therapy office visits.                                                                                                                 |
|                                                               | Telemedicine Visits through plan preferred telemedicine platform <ul style="list-style-type: none"> <li>Primary Care</li> <li>Mental Health</li> <li>Urgent Care</li> </ul> | \$0 Copayment/\$0 Deductible              | Not Covered                                     | <ul style="list-style-type: none"> <li>Primary Care (12 Visit Limit)</li> <li>Mental Health (Crisis Intervention Only, No Therapy)</li> <li>Urgent Care (Unlimited Visits)</li> </ul>                                                                        |
|                                                               | <a href="#">Preventive care/screening/immunization</a>                                                                                                                      | \$0 Copayment / \$0 Deductible            | Not Covered                                     |                                                                                                                                                                                                                                                              |
| <b>If you have a test</b>                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)                                                                                                                         | \$50 Copayment after Deductible           | Not Covered                                     | Limit to 3 visits per benefit period                                                                                                                                                                                                                         |
|                                                               | Imaging (CT/PET scans, MRIs)                                                                                                                                                | \$500 Copayment after Deductible          | Not Covered                                     | Limit to 3 visits per benefit period                                                                                                                                                                                                                         |
| <b>If you need drugs to treat your illness or condition</b>   | Generic drugs                                                                                                                                                               | \$0 Copayment                             | Not Covered                                     | Ventegra is the Pharmacy Benefit Manager                                                                                                                                                                                                                     |
|                                                               | Preferred brand drugs                                                                                                                                                       | Not Covered                               | Not Covered                                     |                                                                                                                                                                                                                                                              |
|                                                               | Non-preferred brand drugs                                                                                                                                                   | Not Covered                               | Not Covered                                     |                                                                                                                                                                                                                                                              |
|                                                               | <a href="#">Specialty drugs</a>                                                                                                                                             | Not Covered                               | Not Covered                                     |                                                                                                                                                                                                                                                              |
| <b>If you have outpatient surgery</b>                         | Facility fee (e.g., ambulatory surgery center)<br>Physician/surgeon fees                                                                                                    | \$250 Copayment after Deductible          | Not Covered                                     | Elective Surgeries Not Covered - Elective surgery refers to a surgical procedure that is planned in advance and is not considered an emergency. This means that the surgery can be postponed without causing immediate harm to the patient's health or life. |

|                                                                                  |                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                     |                                                                                            |                                                                                                                                              |
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| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency room care</a>                                                                                                                                                     | \$300 Copayment after Deductible                                                                                                                                                                                                                                                                    | Covered as In Network Benefit for Emergent Situations- Non-Emergent Situations Not Covered | Limit 3 per benefit period                                                                                                                   |
|                                                                                  | <a href="#">Emergency medical transportation</a>                                                                                                                                        | \$500 Copayment after Deductible                                                                                                                                                                                                                                                                    | Covered as In Network Benefit for Emergent Situations- Non-Emergent Situations Not Covered | Limit 1 transport per benefit period – Ground Ambulance Only                                                                                 |
|                                                                                  | <a href="#">Urgent care</a>                                                                                                                                                             | \$50 Copayment after Deductible                                                                                                                                                                                                                                                                     | Not Covered                                                                                | 10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits, Mental Health Only Therapy office visits. |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room) Physician/surgeon fees                                                                                                                               | \$850 Copayment per admission after Deductible                                                                                                                                                                                                                                                      | Not Covered                                                                                | Paid at facility's semi-private room rate. Combined 3 hospitalizations per benefit period. 5-day limit per hospitalization                   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                                                                                                                                                                     | \$50 Copayment after Deductible                                                                                                                                                                                                                                                                     | Not Covered                                                                                | 10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits, Mental Health Only Therapy office visits. |
|                                                                                  | Outpatient Hospital Services                                                                                                                                                            | Not Covered                                                                                                                                                                                                                                                                                         |                                                                                            |                                                                                                                                              |
|                                                                                  | Inpatient services                                                                                                                                                                      | \$850 Copayment per admission after Deductible                                                                                                                                                                                                                                                      | Not Covered                                                                                | Paid at facility's semi-private room rate. Combined 3 hospitalizations per benefit period. 10-day limit per hospitalization                  |
|                                                                                  | Partial Hospitalization                                                                                                                                                                 | Not Covered                                                                                                                                                                                                                                                                                         |                                                                                            |                                                                                                                                              |
| <b>If you are pregnant</b>                                                       | Routine Vaginal Delivery<br>Routine C-Section Delivery<br>Inpatient Facility<br><br>Professional Services<br>Prenatal / Postnatal<br>All Other Maternity Services<br>NICU<br>Limitation | 100% after deductible<br>100% after deductible<br>\$850 Copay after deductible 2 days - Vaginal 4 days - C-Section - Combined with annual hospitalization limits<br>100% after deductible<br>100% after deductible<br>100% after deductible<br>Same Benefits as Inpatient Hospitalization<br>5 Days | Not Covered                                                                                |                                                                                                                                              |

|                                                                       |                                           |                                  |             |                                                                                                                                                                                                                 |
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| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | \$50 Copayment after Deductible  | Not Covered | Benefits are limited to 20 visits each calendar year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% to a maximum of \$500. \$500 Maximum per benefit year   |
|                                                                       | <a href="#">Rehabilitation services</a>   | \$50 Copayment after Deductible  | Not Covered | 16 visits per member per Plan year. All-inclusive maximum for (Chiropractic, Physical Therapy /Occupational Therapy/Speech Therapy, Cardiac (Pre-certification Required)) office visits.)                       |
|                                                                       | <a href="#">Habilitation services</a>     | \$50 Copayment after Deductible  | Not Covered |                                                                                                                                                                                                                 |
|                                                                       | <a href="#">Skilled nursing care</a>      | \$50 Copayment after Deductible  | Not Covered | Benefits are limited to 20 visits each calendar year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% to a maximum of \$500. \$5,000 Maximum per benefit year |
|                                                                       | <a href="#">Durable medical equipment</a> | \$100 Copayment after Deductible | Not Covered | Precertification is required if cost is \$500 or more \$500 Maximum per benefit year                                                                                                                            |
|                                                                       | <a href="#">Hospice services</a>          | \$0 Copayment after Deductible   | Not Covered | Benefits are limited to 60 days per lifetime \$5,000 Maximum per benefit year                                                                                                                                   |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | Not Covered                      | Not Covered |                                                                                                                                                                                                                 |
|                                                                       | Children's glasses                        | Not Covered                      | Not Covered |                                                                                                                                                                                                                 |
|                                                                       | Children's dental check-up                | Not Covered                      | Not Covered |                                                                                                                                                                                                                 |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does <b>NOT</b> Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                  |                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------------|--|
| • Infertility Treatments                                                                                                                                                                                 | • Weight Loss Programs & Surgery | • Experimental Procedures |  |
| • Private Duty Nursing                                                                                                                                                                                   | • Cosmetic Surgery               | • Maternity               |  |

**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]**

[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](#).

**Language Access Services:** [Spanish (Español): Para obtener asistencia en Español, llame al [866-815-6001] [Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [866-815-6001] [Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[866-815-6001] [Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [866-815-6001]

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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### 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.

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

| Peg is Having a Baby<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                                                                  |        | Managing Joe's Type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)                                                                                                                                                                                 |       | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                                                     |       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| The Plans over all Deductible:                                                                                                                                                                                                                                                                                                           | \$300  | The Plans over all Deductible:                                                                                                                                                                                                                                                       | \$300 | The Plans over all Deductible:                                                                                                                                                                                                                                                    | \$300 |
| Specialist (Cost Sharing):                                                                                                                                                                                                                                                                                                               |        | Specialist (Cost Sharing):                                                                                                                                                                                                                                                           |       | Specialist (Cost Sharing):                                                                                                                                                                                                                                                        |       |
| Hospital (Facility) (Cost Sharing):                                                                                                                                                                                                                                                                                                      |        | Hospital (Facility) (Cost Sharing):                                                                                                                                                                                                                                                  |       | Hospital (Facility) (Cost Sharing):                                                                                                                                                                                                                                               |       |
| Other (Cost Sharing):                                                                                                                                                                                                                                                                                                                    |        | Other (Cost Sharing):                                                                                                                                                                                                                                                                |       | Other (Cost Sharing):                                                                                                                                                                                                                                                             |       |
| This example event includes services like: <ul style="list-style-type: none"> <li>Specialist Office Visits (prenatal care)</li> <li>Childbirth/Delivery Professional Services</li> <li>Childbirth/Delivery Facility Services</li> <li>Diagnostic Tests (Ultrasounds &amp; blood work)</li> <li>Specialist Visits (Anesthesia)</li> </ul> |        | This example event includes services like: <ul style="list-style-type: none"> <li>Primary Care Physician Office Visits (Including disease education)</li> <li>Diagnostic Test (blood work)</li> <li>Prescription Drugs</li> <li>Durable Medical Equipment (glucose meter)</li> </ul> |       | This example event includes services like: <ul style="list-style-type: none"> <li>Emergency Room Care (Including Medical Supplies)</li> <li>Diagnostic Tests (x-ray)</li> <li>Durable medical Equipment (crutches)</li> <li>Rehabilitation Services (Physical Therapy)</li> </ul> |       |
| Total Example Cost: \$12,700                                                                                                                                                                                                                                                                                                             |        | Total Example Cost: \$5,600                                                                                                                                                                                                                                                          |       | Total Example Cost: \$2,800                                                                                                                                                                                                                                                       |       |
| Deductibles:                                                                                                                                                                                                                                                                                                                             | \$300  | Deductibles:                                                                                                                                                                                                                                                                         | \$300 | Deductibles:                                                                                                                                                                                                                                                                      | \$300 |
| Copayments:                                                                                                                                                                                                                                                                                                                              | \$950  | Copayments:                                                                                                                                                                                                                                                                          | \$200 | Copayments:                                                                                                                                                                                                                                                                       | \$450 |
| Coinsurance:                                                                                                                                                                                                                                                                                                                             | \$     | Coinsurance:                                                                                                                                                                                                                                                                         | \$    | Coinsurance:                                                                                                                                                                                                                                                                      | \$    |
| What isn't Covered?                                                                                                                                                                                                                                                                                                                      |        | What isn't Covered?                                                                                                                                                                                                                                                                  |       | What isn't Covered?                                                                                                                                                                                                                                                               |       |
| Limits or Exclusions:                                                                                                                                                                                                                                                                                                                    | \$     | Limits or Exclusions:                                                                                                                                                                                                                                                                | \$    | Limits or Exclusions:                                                                                                                                                                                                                                                             | \$    |
| The total Peg would pay is:                                                                                                                                                                                                                                                                                                              | \$1250 | The total Joe would pay is:                                                                                                                                                                                                                                                          | \$500 | The total Mia would pay is:                                                                                                                                                                                                                                                       | \$750 |