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.cciio.cms.gov.

Important Questions	In- Network		Why This Matters:
Plan Name	Annual Max 100		The Plan Name identifies the specific plan type and its associated benefits, coverage, and cost-sharing arrangements.
What is the overall deductible?	Individual: $ 100	Family: $ 200	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	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	PHCS – Practitioner and Ancillary Only		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 deductible?	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 https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No		You do not have to meet your deductible for specific services.
What is the out-of-pocket limit for this plan?	Individual: $ 0	Family: $ 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	None		There is no annual dollar maximum—the health plan does not impose a limit on the total dollar amount it will pay for covered services for all household members during a plan year.
Maximum Lifetime Benefit Amount per Household	None		There is no lifetime dollar maximum—the health plan does not impose a limit on the total dollar amount it will pay for covered services for all household members.
What is not included in the out-of-pocket limit?	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 network provider?	Yes		If you use an in-network provider, you will pay less. If you use an out-of-network provider, you will pay more and may be subject to balance billing.
Do you need a referral to see a specialist?	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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 Copayment after Deductible	$50 Copayment after Deductible	10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits,PT/OT/ST & Chiro Mental Health Only Therapy office visits.
	Specialist visit	$50 Copayment after Deductible	$50 Copayment after Deductible	10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits,PT/OT/ST & Chiro Mental Health Only Therapy office visits.
	Telemedicine Visits through plan preferred telemedicine platform • Primary Care • Mental Health • Urgent Care	$0 Copayment/$0 Deductible	$0 Copayment/$0 Deductible	• Primary Care (12 Visit Limit) • Mental Health (Crisis Intervention Only, No Therapy) • Urgent Care (Unlimited Visits)
	Preventive care/screening/ immunization	$0 Copayment / $0 Deductible	$0 Copayment/$0 Deductible	
If you have a test	Diagnostic test (x-ray, blood work)	$50 Copayment after Deductible	$50 Copayment after Deductible	Limit to 3 visits per benefit period
	Imaging (CT/PET scans, MRIs)	$250 Copayment	$250 Copayment	Limit to 3 visits per benefit period
If you need drugs to treat your illness or condition	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	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	$250 Copayment	$250 Copayment	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. Limit 2 surgeries per benefit period.

If you need immediate medical attention	Emergency room care	$500 Copayment	$500 Copayment	Limit 3 per benefit period
	Emergency medical transportation	$250 Copayment	$250 Copayment	Limit 1 transport per benefit period – Ground Ambulance Only
	Urgent care	$50 Copayment after Deductible	$50 Copayment after Deductible	10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits,PT/OT/ST & Chiro Mental Health Only Therapy office visits.
If you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fees	$1,000 Copayment per admission after Deductible	$1,000 Copayment per admission after Deductible	Paid at facility's semi-private room rate. Combined 2 hospitalizations per benefit period. 5-day limit per hospitalization
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 Copayment after Deductible	$50 Copayment after Deductible	10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits,PT/OT/ST & Chiro Mental Health Only Therapy office visits.
	Outpatient Hospital Services	Not Covered		
	Inpatient services	$1,000 Copayment per admission after Deductible	$1,000 Copayment per admission after Deductible	Paid at facility's semi-private room rate. Combined 2 hospitalizations per benefit period. 5-day limit per hospitalization
	Partial Hospitalization	Not Covered		
If you are pregnant	Routine Vaginal Delivery Routine C-Section Delivery Inpatient Facility Professional Services Prenatal / Postnatal All Other Maternity Services NICU Limitation	Not Covered	Not Covered	Only ACA mandated services will be eligible under the plan (i.e. screenings and some supplements).

If you need help recovering or have other special health needs	Home health care	$50 Copayment after Deductible	$50 Copayment after Deductible	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
	Rehabilitation services	$50 Copayment after Deductible	$50 Copayment after Deductible	10 visits per member per Plan year. All-inclusive maximum for PCP, Specialist, Urgent Care visits,PT/OT/ST & Chiro Mental Health Only Therapy office visits.
	Habilitation services	$50 Copayment after Deductible	$50 Copayment after Deductible	
	Skilled nursing care	$50 Copayment after Deductible	$50 Copayment after Deductible	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
	Durable medical equipment	$100 Copayment after Deductible	$100 Copayment after Deductible	Precertification is required if cost is $500 or more $500 Maximum per benefit year
	Hospice services	$0 Copayment after Deductible	$0 Copayment after Deductible	Benefits are limited to 60 days per lifetime $5,000 Maximum per benefit year
If your child needs dental or eye care	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Infertility Treatments
- Private Duty Nursing
- Weight Loss Programs & Surgery
- Cosmetic Surgery
- Experimental Procedures
- 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 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, kwiijigo holne' [866-815-6001]

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.

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

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
The Plans over all Deductible:	$300
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 & blood work) • Specialist Visits (Anesthesia)	
Total Example Cost: $12,700	
Deductibles:	$300
Copayments:	$950
Coinsurance:	$
What isn't Covered?	
Limits or Exclusions:	$
The total Peg would pay is:	$1250

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The Plans over all Deductible:	$300
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 Test (blood work) • Prescription Drugs • Durable Medical Equipment (glucose meter)	
Total Example Cost: $5,600	
Deductibles:	$300
Copayments:	$200
Coinsurance:	$
What isn't Covered?	
Limits or Exclusions:	$
The total Joe would pay is:	$500

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The Plans over all Deductible:	$300
Specialist (Cost Sharing):	
Hospital (Facility) (Cost Sharing):	
Other (Cost Sharing):	
This example event includes services like: • Emergency Room Care (Including Medical Supplies) • Diagnostic Tests (x-ray) • Durable medical Equipment (crutches) • Rehabilitation Services (Physical Therapy)	
Total Example Cost: $2,800	
Deductibles:	$300
Copayments:	$450
Coinsurance:	$
What isn't Covered?	
Limits or Exclusions:	$
The total Mia would pay is:	$750