



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 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		Out- of-Network	Why This Matters:
Plan Name	Livelihood 3750 EPO			The Plan Name identifies the specific plan type and its associated benefits, coverage, and cost-sharing arrangements.
What is the overall deductible?	Individual: \$3,750	Family: \$ 7,500	Not Covered	This is the amount you must pay out-of-pocket for covered services before your health plan starts to contribute to the costs.
What is the out-of-pocket limit for this plan?	Individual: \$ 9,200	Family: \$ 18,400	Not Covered	An out-of-pocket maximum is the maximum amount you'll pay for covered healthcare services in a plan year.
Coinsurance	25% / 75%		Not Covered	This is the percentage of the cost for a covered service that you, the insured, pay after you have met your deductible. The plan pays the difference. Example Only: 20% is member responsibility, 80% is plan responsibility.
Plan Type	Exclusive Provider Organization (EPO)			A health benefit plan type defines the structure of how your health plan works, including how you access care, what costs are covered, and how much you pay out-of-pocket.
Additional Plan Information				
Network	Aetna			The network refers to a group of healthcare providers, such as doctors, hospitals, and pharmacies, that have contracted with an health plan company to provide services at discounted rates to the company's members.
Pharmacy Benefit Manager	Kroger			Pharmacy Benefit Manager (PBM) is a company that manages prescription drug benefits for health insurers, employers, and other payers.
Telemedicine Platform / Services	MyLiveDoc - Bowtie			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 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.
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	\$40 Copayment	Not Covered		
	Preventive care/screening/immunization	\$0 Copayment	Not Covered		
	Specialist visit	\$70 Copayment	Not Covered		
Telemedicine Visits	Primary Care	\$0 Copayment	Not Covered		
	Mental Health	\$0 Copayment	Not Covered	Visit Limit – 4 per benefit period – Crisis Intervention Only	
	Urgent Care	\$0 Copayment	Not Covered	Visit Limit – 6 per benefit period	
If you have a test	Diagnostic test (x-ray, blood work)	25% after Deductible	Not Covered	Stand-alone X-Ray/Imaging Center Only - except during Inpatient/E.R. Admissions	
	Imaging (CT/PET scans, MRIs)	25% after Deductible	Not Covered		
Allergy Testing	Shots	\$40 Copayment	Not Covered		
	Testing	\$40 for Physician / 25% after Deductible Testing	Not Covered		
If you need drugs to treat your illness or condition	Generic drugs	Retail: Kroger - 30 Day: \$20 Copayment Mail Order: Kroger - 30 Day: \$30 Copayment - 60 Day: \$50 Copayment - 90 Day: \$60 Copayment	Not Covered		
	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)	25% after Deductible	Not Covered		
	Physician/surgeon fees	25% after Deductible	Not Covered		

If you need immediate medical attention	Emergency room care	25% after Deductible – Waived if Admitted	In Network Level of Benefits	Must be Emergent to Qualify for Out of Network Benefits	
	Emergency medical transportation	\$1,000 Indemnity Benefit after Deductible Visit Limit – 1 per benefit period	In Network Level of Benefits	Must be Emergent to Qualify for Out of Network Benefits	
	Urgent care	\$85 Copayment	Not Covered		
If you have a hospital stay	Facility fee (e.g., hospital room)	25% after Deductible	Not Covered		
	Physician/surgeon fees	25% after Deductible	Not Covered		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	(Example: Intensive Outpatient Program (IOP))	
	Inpatient services	25% after Deductible	Not Covered		
	Therapy	\$40 Copayment	Not Covered	Visit Limit - 25 Combined All Therapy	
	Partial Hospitalization	25% after Deductible	Not Covered	Visit Limit - 10 Days per benefit period	
If you are pregnant	Office visits	100% Covered	Not Covered		
	Childbirth/delivery professional services	25% after Deductible	Not Covered		
	Childbirth/delivery facility services	25% after Deductible	Not Covered		
	NICU	25% after Deductible	Not Covered	Visit Limit – 5 Days	
If you need help recovering or have other special health needs	Home health care	25% after Deductible	Not Covered	Visit limit – 8 per benefit period	
	Rehabilitation services	\$40 Copayment	Not Covered	Visit Limit - 25 Combined All Therapy	
	Habilitation services	\$40 Copayment	Not Covered	Visit Limit - 25 Combined All Therapy	
	Skilled nursing care	25% after Deductible	Not Covered	Visit limit – 8 per benefit period	
	Durable medical equipment	25% after Deductible	Not Covered	\$500 Max Benefit per benefit period	
	Hospice services	25% after Deductible	Not Covered	Visit Limit - 32 Hours per benefit period	
	Prosthetics and Orthotic	25% after Deductible	Not Covered	\$1,000 Max Benefit per benefit period	
	Chemo/Radiation	25% after Deductible	Not Covered		
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	• Experimental or Investigational Treatments
• Weight Loss Programs / Surgery	• Cosmetic Surgery	• Personal Comfort Items

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, kwijjigo holne' [866-815-6001]

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
The Plans over all Deductible:	\$3750	The Plans over all Deductible:	\$3750
Specialist (Cost Sharing):	\$70	Specialist (Cost Sharing):	\$70
Hospital (Facility) (Cost Sharing):	25%	Hospital (Facility) (Cost Sharing):	25%
Other (Cost Sharing):	25%	Other (Cost Sharing):	25%
This example event includes services like: <ul style="list-style-type: none"> Specialist Office Visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic Tests (Ultrasounds & blood work) Specialist Visits (Anesthesia) 		This example event includes services like: <ul style="list-style-type: none"> Primary Care Physician Office Visits (Including disease education) Diagnostic Test (blood work) Prescription Drugs Durable Medical Equipment (glucose meter) 	
Total Example Cost: \$12,700		Total Example Cost: \$5,600	
Deductibles:	\$3750	Deductibles:	\$3750
Copayments:	\$70	Copayments:	\$70
Coinsurance:	\$3175	Coinsurance:	\$1400
What isn't Covered?		What isn't Covered?	
Limits or Exclusions:	\$	Limits or Exclusions:	\$
The total Peg would pay is:		The total Joe would pay is: \$5220	
		What isn't Covered?	
Limits or Exclusions:		Limits or Exclusions: \$	
The total Mia would pay is: \$2800			