|  |
| --- |
| **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 call 1-855-375-7125 to request a copy. |

|  |  |  |
| --- | --- | --- |
| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | [network and out-of-network providers](https://www.healthcare.gov/sbc-glossary/#network-provider):  $1,500 Individual / $4,500 Family  Benefit Period: Per Calendar Year. | Generally, you must pay all of the costs from providers 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 meet 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) , Prescription Drug and Physician 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 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/>. |
| **Are there other**  [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | No | You don’t have to meet [deductible](https://www.healthcare.gov/sbc-glossary/#deductible)sfor specific services. |
| **What is the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | [network and out-of-network providers](https://www.healthcare.gov/sbc-glossary/#network-provider):  $3,750 individual / $11,250 family; | The [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) is 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)**?** | [Premiums](https://www.healthcare.gov/sbc-glossary/#premium), [balance-billing](https://www.healthcare.gov/sbc-glossary/#balance-billing) charges, penalties for failure to obtain [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization), ,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)**?** | No. It is an open access [plan](https://www.healthcare.gov/sbc-glossary/#plan). However, the plan does provide a physician network through the MultiPlan PHCS Practitioner and Ancillary Network. A list of **network** **providers** can be found at [www.multiplan.com](http://www.multiplan.com)  or call 1-888.342.7427. | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) is an open access [plan](https://www.healthcare.gov/sbc-glossary/#plan) |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | No | You can see a [specialist](https://www.healthcare.gov/sbc-glossary/#specialist)you choose without a [referral](https://www.healthcare.gov/sbc-glossary/#referral) |

|  | 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 | $25 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | $25 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | None |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | $50 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | $50 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | Chiropractic Care – Limit 25 visits per Calendar Year |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/  immunization | No Charge | | No Charge | You may have to pay for services that aren’t [preventive](https://www.healthcare.gov/sbc-glossary/#preventive-care). Ask your [provider](https://www.healthcare.gov/sbc-glossary/#provider) if the services you need 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) | Hospital Setting: 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible)  All Other: $0 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ visit; [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | | None |
| Imaging (CT/PET scans, MRIs) | Hospital Setting: 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible)  All Other: $200 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ visit; [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at 844-454-5201 | Generic drugs | $5 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance) Retail  $10 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance) Mail Order | | Not Covered | All Tiers.  Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).  [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) waived for Rx. |
| Preferred brand drugs | $40 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance) Retail  $80 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance) Mail Order | | Not Covered |
| Non-preferred brand drugs | $60 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance) Retail  $120 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance) Mail Order | | Not Covered |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | $100 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance) Retail  $200 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance) Mail Order | | Not Covered |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | | | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| Physician/surgeon fees | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | | | -------------------None------------ |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | $300 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ Visit; [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | | [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance) is waived if admitted as inpatient direct from ER. All facilities are covered as in-network if it meets “emergency” criteria |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | $300 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ Visit; [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | $300 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ Visit; [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | None |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | $50 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | $50 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | | | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| Physician/surgeon fees | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | | | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $50 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | $50 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required for intensive care and partial hospitalization |
| Inpatient services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | | | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| **If you are pregnant** | Office visits | $25 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ 1st Visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | $25 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ 1st Visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | [Cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) does not apply to certain [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care). Depending on the type of services, [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 | $25 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ 1st Visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | $25 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ 1st Visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| Childbirth/delivery facility services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | | | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | $50 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ Visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | $50 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ Visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. Maximum 60 visits per Calendar Year |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | $50 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ Visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | $50 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ Visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. Maximum 30 visits per therapy per Calendar Year. Includes physical therapy, speech therapy, and occupational therapy. |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | $50 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ Visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | | $50 [co-pay](https://www.healthcare.gov/sbc-glossary/#coinsurance)/ Visit;  [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) doesn’t apply | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. Maximum 30 visits per Calendar Year |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | | | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required.  60 day maximum per Calendar Year. |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required |
| **If your child needs dental or eye care** | Children’s eye exam | Not Covered | | Not Covered | None |
| Children’s glasses | Not Covered | | Not Covered | None |
| Children’s dental check-up | Not Covered | | 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 document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | |
| * Acupuncture | * Bariatric Surgery | * Cosmetic Surgery |
| * Hearing Aids | * Long-Term Care | * Non-Emergency Care outside US |
| * Routine Dental Care | * Routine Eye Care | * Routine Foot Care |
| * Weight Loss Programs |  |  |

|  |  |  |
| --- | --- | --- |
| **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.)** | | |
| * Chiropractic Care | * Infertility Services (Basic) |  |

**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: 1-866-444-3272 or [www.dol.gov.ebsa/healthreform](http://www.dol.gov.ebsa/healthreform) . Other coverage options may be available to you too, including buying individual insurance coverage through the 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](https://www.healthcare.gov/sbc-glossary/#plan) for 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 to submit a [claim](https://www.healthcare.gov/sbc-glossary/#claim), [appeal](https://www.healthcare.gov/sbc-glossary/#appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/#plan). For more information about your rights, this notice, or assistance, contact: 888-596-4325.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don’t have [Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-375-7125

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-375-7125.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-375-7125.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-375-7125.

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



**About these Coverage Examples:**

**Peg is Having a Baby**(9 months of in-network pre-natal care and a hospital delivery)

**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.

◼ **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$1,500**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**co-pay**](https://www.healthcare.gov/sbc-glossary/#deductible) **$50**

◼ **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **20%**

◼ **Other** [**co-insurance**](https://www.healthcare.gov/sbc-glossary/#deductible) **50%**

**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** | **$13,540** |

**In this example, Peg would pay:**

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $1,500 |
| Copayments | $340 |
| Coinsurance | $1,400 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,240** |

**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) **$1,500**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**co-pay**](https://www.healthcare.gov/sbc-glossary/#deductible) **$50**

◼ **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **20%**

◼ **Other** [**co-insurance**](https://www.healthcare.gov/sbc-glossary/#deductible) **50%**

**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** | **$4,110**  **The plan would be responsible for the other costs of these EXAMPLE covered services.** |

**In this example, Joe would pay:**

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $1,500 |
| Copayments | $160 |
| Coinsurance | $450 |
| *What isn’t covered* | |
| Limits or exclusions | $290 |
| **The total Joe would pay is** | **$2,400** |

**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) **$1,500**

◼ [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**co-pay**](https://www.healthcare.gov/sbc-glossary/#deductible) **$50**

◼ **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **20%**

◼ **Other** [**co-insurance**](https://www.healthcare.gov/sbc-glossary/#deductible) **50%**

**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** | **$2,900** |

**In this example, Mia would pay:**

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $600 |
| Copayments | $350 |
| Coinsurance | $300 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,250** |