**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services **Coverage Period: 1/01/2025-12/31/2025 Orange Ulster School Districts: Health Plan Coverage for: Individual/Family | Plan Type: PPO**

**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,

www.myLuminareHealth.com. 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 view the Glossary at <https://www.healthcare.gov/sbc-glossary>or call 888-604-9397 to request a copy.

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| **Important Questions** | **Answers** | **Why This Matters:** |  |  |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | [Preferred provider:](https://www.healthcare.gov/sbc-glossary/#network-provider) $0 / individual or $0 / family per calendar year.[Nonpreferred provider:](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) $1,000 / individual or $3,000 / family per calendar year | Generally, you must pay all of the costs from [providers](https://www.healthcare.gov/sbc-glossary/#provider) 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 meets 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. Services by a [preferred provider](https://www.healthcare.gov/sbc-glossary/#network-provider) 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-](https://www.healthcare.gov/coverage/preventive-care-benefits/) |
| [benefits/.](https://www.healthcare.gov/coverage/preventive-care-benefits/) |  |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | Yes. $500 for mental health and substance abuse treatment by a [Nonpreferred provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) This [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) is included in the overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | You must pay all of the costs for these services up to the specific [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan) begins to pay for these services. |
| **What is the** [**out-of-pocket**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)[**limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | [Preferred provider](https://www.healthcare.gov/sbc-glossary/#network-provider) & [Nonpreferred](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) combined [out-of-pocket limit .](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) Medical: $4,650 / individual or $9,300 / family per calendar yearPrescriptions: $2,500 / individual or$5,000 / family per calendar year | The [out-of-pocket limit i](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)s 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)**?** | Penalties for failure to obtain [preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) for services, p[remiums,](https://www.healthcare.gov/sbc-glossary/#premium) [balance-billing](https://www.healthcare.gov/sbc-glossary/#balance-billing) charges, and health carethis [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) |

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022) **Page 1 of 8**

(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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| **Important Questions** | **Answers** | **Why This Matters:** |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. See [www.myluminarehealth.com](http://www.myluminarehealth.com) or call 1- 855-893-4472 for a list of [network providers.](https://www.healthcare.gov/sbc-glossary/#network-provider) | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) uses a [provider](https://www.healthcare.gov/sbc-glossary/#provider) [network.](https://www.healthcare.gov/sbc-glossary/#network) You will pay less if you use a [provider](https://www.healthcare.gov/sbc-glossary/#provider) in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) [network.](https://www.healthcare.gov/sbc-glossary/#network) You will pay the most if you use an [out-of-network provider,](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) and you might receive a bill from a [provider](https://www.healthcare.gov/sbc-glossary/#provider) for the difference between the [provider’s](https://www.healthcare.gov/sbc-glossary/#provider) charge and what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) pays [(balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). Be aware, your [network provider](https://www.healthcare.gov/sbc-glossary/#network-provider) might use an [out-of-](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) for some services (such as lab work). Check with your [provider](https://www.healthcare.gov/sbc-glossary/#provider) before you get services. |
| **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 the [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.

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|  | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information** |
| **Common Medical Event** | **Preferred Provider (You will pay the least)** | **Nonpreferred 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 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)visit | $25 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)visit then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | Member may be billed for charges in excess of Usual & Customary from an [out-of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | $25 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)visit | $25 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)visit then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | Member may be billed for charges in excess of Usual & Customary from an [out-of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care) / [screening](https://www.healthcare.gov/sbc-glossary/#screening) / immunization | No charge | $25 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment)visit then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | You may have to pay for services that aren’t preventive. Ask your [provider](https://www.healthcare.gov/sbc-glossary/#provider) if the services needed are preventive. Then check what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay for. Member may be billed for charges in excess of Usual & Customary from an [out-of-network provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | Outpatient radiology center/Lab/Office: $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)Outpatient hospital: $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)Quest Laboratory:$5 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | Outpatient radiology center/Lab/Office: $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible)Outpatient hospital: $85 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | Member may be billed for charges in excess of Usual & Customary from an [out-of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |

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|  | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information** |
| **Common Medical Event** | **Preferred Provider (You will pay the least)** | **Nonpreferred Provider (You will pay the most)** |
| **If you have a test** | Imaging (CT/PET scans, MRIs) | Outpatient radiology center:$25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)Outpatient hospital: $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | Outpatient radiology center:$25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible)Outpatient hospital: $85 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | Member may be billed for charges in excess of Usual & Customary from an [out-of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| **If you need drugs to treat your illness or condition**More information about [**prescription drug**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage)[**coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at [www.Navitus.com](http://www.Navitus.com) or call 1-855-673-6504. | Generic drugs | Retail 30 day supply: $5 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment) prescriptionMail order or Retail 90 day supply: $10 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment) prescription | [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) does not apply to preventive drugs required by the Affordable Care Act. If you purchase a brand name drug whenthe physician has indicated a generic drugcan be dispensed, you must pay the copay plus the difference in cost.[Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) are limited to a 30 day Supply. |
| Preferred brand drugs | Retail 30 day supply: $35 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment) prescriptionMail order or Retail 90 day supply: $70 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment) prescription |
| Non-preferred brand drugs | Retail 30 day supply: $60 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment) prescriptionMail order or Retail 90 day supply: $120 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/ prescription |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | Preferred Brand $35 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment) prescription Non-preferred Brand $60 [copay/](https://www.healthcare.gov/sbc-glossary/#copayment) prescription |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | $85 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) then 25% [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 for certain outpatient procedures. If [preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is not obtained, benefits could be reduced by$500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customary from an [out-of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| Physician/surgeon fees | $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | Member may be billed for charges in excess of Usual & Customary from an [out-of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |

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|  | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information** |
| **Common Medical Event** | **Preferred Provider (You will pay the least)** | **Nonpreferred Provider (You will pay the most)** |
| **If you need immediate medical attention** | [Emergency room](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) [care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | Emergency Care: $100 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)Non-Emergency Care: $100 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | Emergency Care: [Preferred](https://www.healthcare.gov/sbc-glossary/#network-provider) [provider](https://www.healthcare.gov/sbc-glossary/#network-provider) benefit applies.Non-Emergency Care:$120 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) [copay](https://www.healthcare.gov/sbc-glossary/#copayment) waived if admitted. |
| [Emergency medical](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) [transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | $70 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | [Preferred provider](https://www.healthcare.gov/sbc-glossary/#network-provider) benefit applies. | None. |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | $35 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | $45 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | Member may be billed for charges in excess of Usual & Customary from an [out-of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $100 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) per admission | $500 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) per admission then 25% [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 [preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is not obtained, benefits could be reduced by $500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customaryfrom an [out-of-network provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| Physician/surgeon fees | No Charge | 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | Member may be billed for charges in excess of Usual & Customary from an [out-of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after $500 [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | Contact Quantum Health at (888)214-4001 for mental health, behavioral health and substance abuse services. [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If [preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is not obtained, benefits could be reduced by $500 of the total cost of the service. Member may be billed for charges in excess of Usual &Customary from an [out-of-network provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| Inpatient services | $100 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) per admission | $500 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) per admission then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after$500 [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) |
| **If you are pregnant** | Office visits | Initial Visit: $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) Routine prenatal and initial postnatal: 0% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | Dependent daughters are covered for this benefit.[Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required for routine and |

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|  | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information** |
| **Common Medical Event** | **Preferred Provider (You will pay the least)** | **Nonpreferred Provider (You will pay the most)** |
|  | Childbirth/delivery professional services | $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | high risk maternity (routine only if inpatient stay exceeds federal requirements). If [preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is not obtained, benefits could be reduced by $500 of the total cost of the service. [Cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) does not apply for [preventive services.](https://www.healthcare.gov/sbc-glossary/#preventive-care) Depending on the type of services, a [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) and [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Member may be billed for charges in excess of Usual & Customary froman [out-of-network provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| Childbirth/delivery facility services | $100 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) per admission | $500 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) per admission then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | No Charge | 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | Limited to 180 visits per calendar year. [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If [preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is not obtained, benefits could be reduced by $500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customary from an [out-of-network provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| [Rehabilitation](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) [services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | Member may be billed for charges in excess of Usual & Customary from an [out-of-](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [network provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | Not Covered | Not Covered | None. |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | $100 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) per admission | $500 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) per admission then 25% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) after [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) | 180 days per calendar year. [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required. If [preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is not obtained, benefits could be reduced by $500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customary from an [out-of-network provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |

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|  | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information** |
| **Common Medical Event** | **Preferred Provider (You will pay the least)** | **Nonpreferred Provider (You will pay the most)** |
|  | [Durable medical](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) [equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) | $25 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) then 25% [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 for equipment over $1500 (except insulin pumps). If [preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is not obtained, benefits could be reduced by $500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customaryfrom an [out-of-network provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | No Charge | No Charge | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is required for inpatient services. If [preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is not obtained, benefits could be reduced by $500 of the total cost of the service. Member may be billed for charges in excess of Usual & Customary from an [out-of-network provider.](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) |
| **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:

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| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** |
| * Cosmetic surgery
* Dental care (Adult)
 | * Long-term care
* Non-emergency care when traveling outside the U.S.
 | * Routine eye care (Adult)
* Routine foot care
* Weight loss programs
 |

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| **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.)** |
| * Acupuncture
* Bariatric surgery
* Chiropractic Care (prior authorization required)
 | * Hearing Aids
* Infertility Treatment (limitations apply)
 | * Private-duty nursing (only covered as part of home health care services)
 |

**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: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (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](https://www.healthcare.gov/sbc-glossary/#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 f](https://www.healthcare.gov/sbc-glossary/#plan)or 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 on how to submit a [claim,](https://www.healthcare.gov/sbc-glossary/#claim) [appeal,](https://www.healthcare.gov/sbc-glossary/#appeal) or a [grievance f](https://www.healthcare.gov/sbc-glossary/#grievance)or any reason to your [plan.](https://www.healthcare.gov/sbc-glossary/#plan) For more information about your rights, this notice, or assistance, contact: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform.](http://www.dol.gov/ebsa/healthreform)

# Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) generally includes [plans,](https://www.healthcare.gov/sbc-glossary/#plan) [health insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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,](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) you may not be eligible for the [premium tax credit.](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits)

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

# Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-604-9397.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-604-9397. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-604-9397.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-604-9397.

***To see examples of how this*** [***plan***](https://www.healthcare.gov/sbc-glossary/#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](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.

**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** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$0**
* [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **$25**
* **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **100%**
* **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **100%**

**This EXAMPLE event includes services like:** [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) office visits *(prenatal care)* Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(ultrasounds and blood work)*

[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit *(anesthesia)*

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| --- | --- |
| **Total Example Cost** | **$12,700** |

# In this example, Peg would pay:

* **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$0**
* [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **$25**
* **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **100%**
* **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **100%**

**This EXAMPLE event includes services like:** [Primary care physician](https://www.healthcare.gov/sbc-glossary/#primary-care-physician) office visits *(including disease education)*

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(blood work)*

[Prescription drugs](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage)

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(glucose meter)*

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| **Total Example Cost** | **$5,600** |

# In this example, Joe would pay:

* **The** [**plan’s**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) **$0**
* [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist) [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) **$25**
* **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **100%**
* **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) **100%**

**This EXAMPLE event includes services like:** [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) *(including medical supplies)*

[Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (*x-ray*)

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(crutches)*

[Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) *(physical therapy)*

|  |  |
| --- | --- |
| **Total Example Cost** | **$2,800** |

# In this example, Mia would pay:

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| *Cost Sharing* |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $0 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $200 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$200** |

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| *Cost Sharing* |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $0 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $405 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$405** |

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| *Cost Sharing* |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $0 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $255 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $0 |
| *What isn’t covered* |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$255** |

The [plan](https://www.healthcare.gov/sbc-glossary/#plan) would be responsible for the other costs of these EXAMPLE covered services.