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, visit https://portal.securusbenefits.com or call +18774200785. 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.healthcare.gov/sbc-glossary or call +18774200785 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: Individual: $2,500.00, Family: $5,000.00 Out of Network: Individual: $5,000.00, Family: $10,000.00	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Pharmacy: Generic drug (90 day supply), Preferred drug (30 day supply), Non-Preferred drug (90 day supply), Specialty drug (30 day supply), Non-Preferred drug (30 day supply), Preferred drug (90 day supply), Generic drug (30 day supply) In Network: Many services. See the grid below for details.	This plan covers some items and services even if you haven't yet met the deductible amount. But 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In Network: Individual: $7,350.00, Family: $14,700.00 Out of Network: Individual: $14,700.00, Family: $29,400.00	The 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, pre-certification penalties, balance-billed charges, & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of pocket limit.
Will you pay less if you use a network provider?	You may pay less if you use a network provider.	
Do you need a referral to	No.	You can see the specialist you choose without a referral.

Important Questions	Answers	Why This Matters:
see a specialist?		

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	In Network: $30.00 Copay Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Specialist visit	In Network: $60.00 Copay Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Preventive care/screening/ immunization	In Network: No charge Out of Network: 40% Coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Imaging (CT/PET scans, MRIs)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling +18885893340	Generic drugs	30 Day Supply: $15.00 Copay 90 Day Supply: $45.00 Copay	
	Preferred brand drugs	30 Day Supply: $45.00 Copay 90 Day Supply: $90.00 Copay	
	Non-preferred brand drugs	30 Day Supply: $85.00 Copay 90 Day Supply: $150.00 Copay	
	Specialty drugs	30 Day Supply: 50% Coinsurance 90 Day Supply: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	
	Physician/surgeon fees	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need immediate medical attention	Emergency room care	In Network: 20% Coinsurance after deductible Out of Network: 20% Coinsurance after deductible	
	Emergency medical transportation	In Network: 20% Coinsurance after deductible Out of Network: 20% Coinsurance after deductible	Some procedures may need pre-certification.
	Urgent care	In Network: $60.00 Copay	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
		Out of Network: 40% Coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Physician/surgeon fees	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	In Network: $30.00 Copay Out of Network: 40% Coinsurance after deductible	
	Inpatient services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you are pregnant	Office visits	In Network: $30.00 Copay Out of Network: 40% Coinsurance after deductible	
	Childbirth/delivery professional services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	
	Childbirth/delivery facility services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
If you need help recovering or have other special health needs	Home health care	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	60 visits per year. Some procedures may need pre-certification.
	Rehabilitation services	In Network: $30.00 Copay Out of Network: 40% Coinsurance after deductible	20 visits per year. Some procedures may need pre-certification.
	Habilitation services	In Network: $30.00 Copay Out of Network: 40% Coinsurance after deductible	20 visits per year. Some procedures may need pre-certification.
	Skilled nursing care	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	60 days per year.
	Durable medical equipment	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	Some procedures may need pre-certification.
	Hospice services	In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible	
If your child needs dental or eye care	Children's eye exam	$0	Limited to one exam every 24 months except if required more frequently under the Affordable Care Act
	Children's glasses	Not Covered	Glasses are not covered.
	Children's dental check-up	Not Covered	Dental services are not covered.

Excluded Services & Other Covered Services:

For more information about limitations and exceptions, see the plan or policy document at https://portal.securusbenefits.com/signin

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
Specialty drug (90 day supply), Infertility, Hearing Aids, Experimental Therapies, Electroconvulsive Therapy, Abortion, Sterilization Reversal, Impotence, Massage, Reporting Codes, Biofeedback, Surrogacy, Gender Affirming Care, Obesity Treatment, Orthopedic Shoes (Except Diabetics)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
Cardiac Rehabilitiation, Hospital Outpatient, Acupuncture, Radiation and Chemotherapy, Chiropractic Services, Adult Eye Exam, Laboratory/Diagnostics, Injections, Private Duty Nursing, Freestanding Laboratory

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: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA. 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: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA.

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 +18774200785.

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

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.

Peg is Having a Baby

(9 months of pre-natal care and a hospital delivery)

The plan's overall deductible
$2,500.00

Specialist copay	**$60**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$12,700.00**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500.00
Copayments	$120.00
Coinsurance	$2,040.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$4,660.00**

Managing Joe's Type 2 Diabetes

(A year of routine care of a well-controlled condition)

The plan's overall deductible
$2,500.00

Specialist copay	**$60**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs *(preferred brand)*
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600.00**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,500.00
Copayments	$75.00
Coinsurance	$620.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$3,195.00**

Mia's Simple Fracture

(Emergency room visit and follow up care)

The plan's overall deductible
$2,500.00

Specialist copay	**$60**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$2,800.00**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,500.00
Copayments	$30.00
Coinsurance	$60.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$2,590.00**

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