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, [insert contact information]. 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 1-866-357-4082 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $5,000 Individual/$10,000 Family	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?	Yes. Preventive care/screening/immunization do not apply toward the deductible.	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?	Network: $7,500 Individual/$15,000 Family	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 limit limit until the overall family out-of-pocket limit limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization for services and health care this plan does not 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?	Yes. See 22healthplan.com/findaprovider or call 1-866-357-4082 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	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	$25 copay / visit	Not Covered	None
	Specialist visit	$70.00 copay after deductible	Not Covered	None
	Preventive care/screening/ immunization	No Charge, Deductible does not apply	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	40.00% Coinsurance after deductible	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40.00% Coinsurance after deductible	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.22healthplan.com	Generic drugs	$40.00	Not Covered	None
	Preferred brand drugs	$50.00	Not Covered	None
	Non-preferred brand drugs	50.00% Coinsurance after deductible	Not Covered	None
	Specialty drugs	50.00% Coinsurance after deductible	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40.00% Coinsurance after deductible	Not Covered	None
	Physician/surgeon fees	40.00% Coinsurance after deductible	Not Covered	None
If you need immediate medical attention	Emergency room care	50.00% Coinsurance after deductible	50.00% Coinsurance after deductible	None
	Emergency medical transportation	50.00% Coinsurance after deductible	50.00% Coinsurance after deductible	None
	Urgent care	$60 copay / visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40.00% Coinsurance after deductible	Not Covered	None
	Physician/surgeon fees	40.00% Coinsurance after deductible	Not Covered	None

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay / visit	Not Covered	None
	Inpatient services	40.00% Coinsurance after deductible	Not Covered	None
If you are pregnant	Office visits	$25 copay / visit	Not Covered	None
	Childbirth/delivery professional services	40.00% Coinsurance after deductible	Not Covered	None
	Childbirth/delivery facility services	40.00% Coinsurance after deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	40.00% Coinsurance after deductible	Not Covered	20 Days per Benefit Period
	Rehabilitation services	40.00% Coinsurance after deductible	Not Covered	35 Visits per Benefit Period
	Habilitation services	40.00% Coinsurance after deductible	Not Covered	None
	Skilled nursing care	$700.00 Copay per Day	Not Covered	60 Days per Benefit Period
	Durable medical equipment	40.00% Coinsurance after deductible	Not Covered	None
	Hospice services	40.00% Coinsurance after deductible	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	1 Exam per year
	Children's glasses	No Charge	Not Covered	1 pair per year
	Children's dental check-up	Not Covered	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.)

- Abortion - (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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 document.)		
• Prescription and non-prescription enteral Formulas are limited to $2,500 per benefit period.	• Chiropractic care • Physical Therapy • Occupational Therapy • Speech Therapy	• Coverage is limited to 35 visits for Physical Therapy, Occupational Therapy, Speech Therapy and Chiropractic care combined.

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 1-866-357-4082.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-357-4082.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-357-4082.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-357-4082.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

The plan's overall deductible	**$5,000**
Specialist Copayment	**$70.00**
Hospital (facility) Coinsurance	**40%**
Other Coinsurance	**40%**

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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$50
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$6,750

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$5,000**
Specialist Copayment	**$70.00**
Hospital (facility) Coinsurance	**40%**
Other Coinsurance	**40%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,200
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$2,100

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$5,000**
Specialist Copayment	**$70.00**
Hospital (facility) Coinsurance	**40%**
Other Coinsurance	**40%**

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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,795
Copayments	$5
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,800

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