



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: \$0 Individual/\$0 Family | See the Common Medical Events chart below for your costs for services this plan covers. |
| 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 deductible s for specific services. |
| What is the out-of-pocket limit for this plan? | Network: \$0 Individual/\$0 Family | This plan does not have an out-of-pocket limit limit on your expenses |
| What is not included in the out-of-pocket limit? | Not Applicable | This plan does not have an out-of-pocket limit limit on your expenses |
| 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 | | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No Charge | Not Covered | None |
| | Specialist visit | No Charge | Not Covered | None |
| | Preventive care/screening/immunization | No Charge, <u>Deductible</u> does not apply | Not Covered | None |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No Charge | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | No Charge | Not Covered | None |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.22healthplan.com | Generic drugs | No Charge | Not Covered | None |
| | Preferred brand drugs | No Charge | Not Covered | None |
| | Non-preferred brand drugs | No Charge | Not Covered | None |
| | <u>Specialty drugs</u> | No Charge | Not Covered | None |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | Not Covered | None |
| | Physician/surgeon fees | No Charge | Not Covered | None |
| If you need immediate medical attention | <u>Emergency room care</u> | No Charge | No Charge | None |
| | <u>Emergency medical transportation</u> | No Charge | No Charge | None |
| | <u>Urgent care</u> | No Charge | Not Covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | Not Covered | None |
| | Physician/surgeon fees | No Charge | Not Covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No Charge | Not Covered | None |
| | Inpatient services | No Charge | 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 are pregnant | Office visits | No Charge | Not Covered | None |
| | Childbirth/delivery professional services | No Charge | Not Covered | None |
| | Childbirth/delivery facility services | No Charge | Not Covered | None |
| If you need help recovering or have other special health needs | Home health care | No Charge | Not Covered | 20 Days per Benefit Period |
| | Rehabilitation services | No Charge | Not Covered | 35 Visits per Benefit Period |
| | Habilitation services | No Charge | Not Covered | None |
| | Skilled nursing care | No Charge | Not Covered | 60 Days per Benefit Period |
| | Durable medical equipment | No Charge | Not Covered | None |
| | Hospice services | No Charge | 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

22H-SBC-01/2026 * For more information about limitations and exceptions, see the plan or policy document at www.22healthplan.com.

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 | \$0.00 |
| Specialist No Charge | \$0.00 |
| Hospital (facility) No Charge | \$0.00 |
| Other No Charge | \$0.00 |

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 | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$0 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---------------------------------|--------|
| ■ The plan's overall deductible | \$0.00 |
| Specialist No Charge | \$0.00 |
| Hospital (facility) No Charge | \$0.00 |
| Other No Charge | \$0.00 |

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 | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$0 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---------------------------------|--------|
| ■ The plan's overall deductible | \$0.00 |
| Specialist No Charge | \$0.00 |
| Hospital (facility) No Charge | \$0.00 |
| Other No Charge | \$0.00 |

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 | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$0 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.