



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, please call 1-844-462-6334. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underline terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or by calling 1-844-462-6334 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For Network providers \$4,500/individual or \$9,000/family; for Non-network providers \$8,500/individual or \$17,000 family	Generally, you must pay all 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 services are covered before you meet your 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, but see chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	For Network providers \$8,150 individual / \$16,300 family; for Non-network providers \$20,000/individual or \$40,000/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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balanced-billing charges, and 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 ?	Yes. Go to https://providersearch.multiplan.com 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 don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

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	\$40 copay /visit	Deductible, 50% coinsurance subject to Plan's allowable fee	None
	Specialist visit	\$75 copay /visit	Deductible, 50% coinsurance subject to Plan's allowable fee	None
	Chiropractic Care	30% after deductible	Deductible, 50% coinsurance subject to Plan's allowable fee	None
	Preventive care/screening/immunization	No Charge	Deductible, 50% coinsurance subject to Plan's allowable fee	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (blood work and X-ray)	30% after deductible *	Deductible, 50% coinsurance subject to Plan's allowable fee	See footnote below.
	Imaging (CT/PET scans, MRIs)	30% after deductible *	Deductible, 50% coinsurance subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum). See footnote below.
If you need drugs to treat your illness or condition prescription drug	Generic drugs	Preventive 1-30 day supply \$0 copayment/prescription Non-Preventive 1-30 day supply \$20 copayment/prescription	Not covered	Covers up to a 30-day supply (retail);
	Preferred brand drugs	1-30 day supply \$65 copayment/prescription	Not covered	Step therapy applies – includes the use of therapeutic alternatives.
	Non-preferred brand drugs	1-30 day supply \$95 copayment/prescription	Not covered	*Members must call MBA TPA at 844-462-6334 to determine eligibility criteria and benefit options.
	Specialty drugs	1-30 day supply \$200 copayment/prescription	Not covered	Prior authorization is required for all Specialty drugs. Contact MBA TPA at 844-462-6334

*\$500 First dollar coverage combined for Outpatient Laboratory, Radiology, & Scans, then Deductible & Coinsurance

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500
	Physician/surgeon fees	30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
If you need immediate medical attention	Emergency room care	Facility: 30% after deductible Professional Fees: 30% after deductible	Facility: Deductible, 50% coinsurance subject to Plan's allowable fee Professional Fees: Deductible, 50% coinsurance subject to Plan's allowable fee	None
	Emergency medical	30% after deductible	Deductible, 50% coinsurance subject to Plans allowable fee	None
	Urgent care	\$90 <u>copay</u> /visit	Deductible, 50% coinsurance subject to Plans allowable fee	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% after deductible	Deductible, 50% coinsurance subject to Plans allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500
	Physician/surgeon fees	30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
If you need mental health, behavioral health and substance abuse services	Outpatient services	30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
	Inpatient services	Facility: 30% after deductible Professional Fees: 30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
If you are pregnant	Office visits	\$75 <u>copay</u> /visit	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	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)	
	Childbirth/delivery professional services	30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
	Childbirth/delivery facility services	30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	None
If you need help recovering or have other special health needs	Home health care	30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	200 visits per benefit period maximum. Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
	Rehabilitation services	30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	(Combined limit of 30 visits per plan year with physical, speech, and occupational therapies. Prior authorization is required after 6 visits.)
	Habilitation services	30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	
	Skilled nursing care	Facility: 30% after deductible Professional Fees: 30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	
	Durable medical equipment	30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
	Hospice services	30% after deductible	Deductible, 50% <u>coinsurance</u> subject to Plan's allowable fee	Failure to obtain precertification will result in a 50% benefit reduction (\$2,500 maximum).
If your child needs dental or eye care	Routine 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](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatments
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Chiropractic Care
- Durable medical equipment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends.

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 to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#).

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [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](#) 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](#).

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	\$4,500
■ Specialist [copayment]	\$75
■ Hospital (facility) [coinsurance]	30%
■ Other [coinsurance]	30%

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	\$12,580
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$4,500
Copayments	\$75
Coinsurance	\$2,401.50
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$6,976.50

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$4,500
■ Specialist [copayment]	\$75
■ Hospital (facility) [coinsurance]	30%
■ Other [coinsurance]	30%

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	\$4,000
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,925
Copayments	\$140
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,935

Mia's Simple Fracture

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

■ The plan's overall deductible	\$4,500
■ Specialist [copayment]	\$75
■ Hospital (facility) [coinsurance]	30%
■ Other [coinsurance]	30%

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	\$3,500
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$3,500