



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, call 877.240.9228. 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 877.240.9228 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network and Out-of-Network : \$3,500 Individual / \$6,700 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. Certain preventive care is 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	There are no other specific deductibles .
What is the out-of-pocket limit for this plan ?	Network and Out-of-Network : \$6,900 Individual / \$13,800 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 , balance-billing charges, preauthorization penalties, 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. See myhealthhub.app or call 877.240.9228 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 Healthcare Highways (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	20% coinsurance	50% coinsurance	Telemedicine visits are available, please refer to your plan policy for more details. MDLive virtual care \$0 cost to member.
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	30% coinsurance	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. No Charge for mammograms, child immunizations, or certain diagnostic tests Out-of-Network .
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at liviniti.com/members	Preferred generic drugs	20% coinsurance	Not covered	Applies after benefit period deductible is met. Retail limited to 30-day supply. Mail order and ESN limited to 90-day supply of maintenance drugs. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Specialty drugs should be obtained from Network specialty pharmacy provider . 20% penalty if any other vendor is used. Limited to a 30-day supply. Mail order is not covered.
	Non-preferred generic drugs	20% coinsurance	Not covered	
	Preferred brand drugs	20% coinsurance	Not covered	
	Non-preferred brand drugs	20% coinsurance	Not covered	
	Specialty drugs	20% coinsurance	Not covered	
	Non-preferred specialty drugs	20% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Elective abortion is not covered.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None

* For more information about limitations and exceptions, see the [plan](#) or policy document at [myhealthhub.app](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider Healthcare Highways (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Facility Charges: 20% coinsurance ER Physician Charges: 20% coinsurance	Facility Charges: 20% coinsurance ER Physician Charges: 20% coinsurance	None
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	None
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization required; Claims denied if not obtained.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Preauthorization required for certain services; Claims denied if not obtained. Telemedicine visits are available, please refer to your plan policy for more details.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization required; Claims denied if not obtained.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, applicable Cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Preauthorization required for complications or stays exceeding 48 hours (vaginal delivery or 96 hours (C-section); Claims denied if not obtained.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	100 visit limit per benefit period. Preauthorization required; Claims denied if not obtained.
	Rehabilitation services	20% coinsurance	50% coinsurance	Outpatient: Combined 25 visit limit per benefit period for physical, occupational, speech, and muscle manipulation therapies. Exception for speech therapy no visit limit children ages 7 – 17.
	Habilitation services	20% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see the [plan](#) or policy document at myhealthhub.app.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider Healthcare Highways (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Inpatient: 30-day limit per benefit period. Preauthorization required; Claims denied if not obtained.
	Skilled nursing care	20% coinsurance	50% coinsurance	100-day limit per benefit period. Preauthorization required; Claims denied if not obtained.
	Durable medical equipment	20% coinsurance	50% coinsurance	Medically necessary rental or purchase at the plan 's discretion.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization required; Claims denied if not obtained.
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:

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
- Cosmetic surgery
- Dental care (Adult)
- Elective abortion (unless the life of the pregnant individual is endangered)
- Hearing aids (limited coverage for children)
- Long-term care
- 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.)

- Bariatric surgery (member must be enrolled in the health [plan](#) for 2 consecutive years in order to be eligible, services must be performed at a Centers of Excellence.
- Chiropractic care
- Infertility treatment ([diagnostic](#) services and injections only)
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (85 visits per year)

* For more information about limitations and exceptions, see the [plan](#) or policy document at myhealthhub.app.

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#).

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 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 877.240.9228

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877.240.9228

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 877.240.9228

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 877.240.9228

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

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* For more information about limitations and exceptions, see the [plan](#) or policy document at myhealthhub.app.

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	\$3,500
■ Specialist coinsurance	20%
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$1,800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,360

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$3,500
■ Specialist coinsurance	20%
■ 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
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$3,500
Copayments	\$0
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3,920

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,500
■ Specialist coinsurance	20%
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800