



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, 1-833-569-7325. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-833-569-7325 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0/Individual or<br>\$0/family                                                                                                                                               | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> , primary care services and <a href="#">prescription drug</a> benefits are covered before you meet your <a href="#">deductible</a> .     | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$0 individual / \$0 family                                                                                                                                                   | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.peakhealth.org">www.peakhealth.org</a> or call 1-833-569-7325 for a list of <a href="#">network providers</a> .                                  | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |



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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                              |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                             | Primary care visit to treat an injury or illness       | \$0 <a href="#">copay</a> /office visit      | Not Covered                                        | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. |
|                                                                                                                                                                                    | <a href="#">Specialist</a> visit                       | \$0 <a href="#">copay</a> /office visit      | Not Covered                                        |                                                                                                                                                                                                              |
|                                                                                                                                                                                    | <a href="#">Preventive care/screening/immunization</a> | No charge                                    | Not Covered                                        |                                                                                                                                                                                                              |
| If you have a test                                                                                                                                                                 | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 0% <a href="#">coinsurance</a>               | Not Covered                                        | None                                                                                                                                                                                                         |
|                                                                                                                                                                                    | Imaging (CT/PET scans, MRIs)                           | 0% <a href="#">coinsurance</a>               | Not Covered                                        |                                                                                                                                                                                                              |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">memberportal.navitus.com</a> | Generic drugs                                          | \$0 <a href="#">copay</a> /prescription      | Not Covered                                        | Copays shown cover for up to a 30-day supply                                                                                                                                                                 |
|                                                                                                                                                                                    | Preferred brand drugs                                  | \$0 <a href="#">copay</a> /prescription      | Not Covered                                        |                                                                                                                                                                                                              |
|                                                                                                                                                                                    | Non-preferred brand drugs                              | \$0 <a href="#">copay</a> /prescription      | Not Covered                                        |                                                                                                                                                                                                              |
|                                                                                                                                                                                    | <a href="#">Specialty drugs</a>                        | \$0 <a href="#">copay</a> /prescription      | Not Covered                                        |                                                                                                                                                                                                              |
| If you have outpatient surgery                                                                                                                                                     | Facility fee (e.g., ambulatory surgery center)         | 0% <a href="#">coinsurance</a>               | Not Covered                                        | <a href="#">Preauthorization</a> may be required                                                                                                                                                             |
|                                                                                                                                                                                    | Physician/surgeon fees                                 | 0% <a href="#">coinsurance</a>               | Not Covered                                        | <a href="#">Preauthorization</a> may be required                                                                                                                                                             |
| If you need immediate medical attention                                                                                                                                            | <a href="#">Emergency room care</a>                    | 0% <a href="#">coinsurance</a>               | 0% <a href="#">coinsurance</a>                     | None                                                                                                                                                                                                         |
|                                                                                                                                                                                    | <a href="#">Emergency medical transportation</a>       | 0% <a href="#">coinsurance</a>               | 0% <a href="#">coinsurance</a>                     |                                                                                                                                                                                                              |
|                                                                                                                                                                                    | <a href="#">Urgent care</a>                            | \$0 <a href="#">copay</a> /visit             | \$0 <a href="#">copay</a> /visit                   |                                                                                                                                                                                                              |
| If you have a hospital stay                                                                                                                                                        | Facility fee (e.g., hospital room)                     | 0% <a href="#">coinsurance</a>               | Not Covered                                        | <a href="#">Preauthorization</a> may be required                                                                                                                                                             |
|                                                                                                                                                                                    | Physician/surgeon fees                                 | 0% <a href="#">coinsurance</a>               | Not Covered                                        | <a href="#">Preauthorization</a> may be required                                                                                                                                                             |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                        |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Network Provider<br>(You will pay the least)                                                             | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                        |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$0 <a href="#">copay</a> /office visit and 0% <a href="#">coinsurance</a> for other outpatient services | Not Covered                                        | <a href="#">Preauthorization</a> may be required                                                                                                                                                                                                                       |
|                                                                           | Inpatient services                        | 0% <a href="#">coinsurance</a>                                                                           | Not Covered                                        |                                                                                                                                                                                                                                                                        |
| If you are pregnant                                                       | Office visits                             | 0% <a href="#">coinsurance</a>                                                                           | Not Covered                                        | <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services | 0% <a href="#">coinsurance</a>                                                                           | Not Covered                                        |                                                                                                                                                                                                                                                                        |
|                                                                           | Childbirth/delivery facility services     | 0% <a href="#">coinsurance</a>                                                                           | Not Covered                                        |                                                                                                                                                                                                                                                                        |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 0% <a href="#">coinsurance</a>                                                                           | Not Covered                                        | 100 visits/year                                                                                                                                                                                                                                                        |
|                                                                           | <a href="#">Rehabilitation services</a>   | \$0 <a href="#">copay</a> /visit                                                                         | Not Covered                                        | 30 visits/year each for Occupational and Physical Therapies                                                                                                                                                                                                            |
|                                                                           | <a href="#">Habilitation services</a>     | \$0 <a href="#">copay</a> /visit                                                                         | Not Covered                                        | 30 visits/year each for Occupational and Physical Therapies                                                                                                                                                                                                            |
|                                                                           | <a href="#">Skilled nursing care</a>      | 0% <a href="#">coinsurance</a>                                                                           | Not Covered                                        |                                                                                                                                                                                                                                                                        |
|                                                                           | <a href="#">Durable medical equipment</a> | 0% <a href="#">coinsurance</a>                                                                           | Not Covered                                        | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.                                                                                                                                                                                  |
|                                                                           | <a href="#">Hospice services</a>          | 0% <a href="#">coinsurance</a>                                                                           | Not Covered                                        | <a href="#">Preauthorization</a> may be required                                                                                                                                                                                                                       |
| If your child needs dental or eye care                                    | Children's eye exam                       | No Charge                                                                                                | Not covered                                        | Coverage limited to one exam/year.                                                                                                                                                                                                                                     |
|                                                                           | Children's glasses                        | No Charge                                                                                                | Not covered                                        | Coverage limited to one pair of glasses/year.                                                                                                                                                                                                                          |
|                                                                           | Children's dental check-up                | No charge                                                                                                | 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](#).)

- Cosmetic Surgery
- Long Term Care
- Routine eye care (Adult)
- Dental Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care

**Other Covered Services** (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric Surgery
- Chiropractic Care
- Pediatric Dental

**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:

1-888-879-9842. 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](http://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](#). For more information about your rights, this notice, or assistance, contact the Plan at 1-833-569-7325.

**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 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 1-833-569-7325.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-569-7325.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-569-7325.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-569-7325.

---

*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
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

**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 |
| What isn't covered              |     |
| 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
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

**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 |
| What isn't covered              |     |
| 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
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

**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 |
| What isn't covered              |     |
| 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.