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 1-800-221-4254. 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.claimchoice.com or call 1-800-221-4254 to request a copy.

Important Questions	Answers		Why this Matters:
What is the overall deductible?	**In-Network:** $0/person $0/family	**Out-of-Network:** $1,500/person $3,000/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, the following services are covered before you meet your deductible – Preventive Care, Obstetric care (Professional Services). care, urgent care, specialist visits Prescription drug coverage, emergency room care, ABA treatment, routine immunizations administered in a pharmacy or at the Department of Community Health, and any eligible services coordinated by Sympl Care and are also covered before you meet your deductible.		This plan covers some items and services even if you haven't 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?	**In-Network:** $ 6,600 /person $ 13,200 /family	**Out-of-Network:** $19,800/person $39,600/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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Balance-billing charges, health care the plan doesn't cover, and penalties for failing to follow precertification.		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 of providers?	Yes. See www.cofinity.net or call 1-800-831-1166 for a list of participating 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 the provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware that 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 I need a referral to see a specialist?	No.		You can see the specialist you chose without a referral.

Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed below. See your policy or plan document/SPD for additional information about 'excluded services'

- **Copayments** are fixed dollar amounts (for example, $35.00) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% v change if you haven't met your deductible.
- **The amount** the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	50% coinsurance	None
	Specialist visit	$45 copay/visit	50% coinsurance	None
	Preventive care/screening/immunization	No Charge	Not Covered	No coverage out of network. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	Pre-certification required for services. $250 penalty for non-compliance.
	Imaging (CT/PET scans, MRIs)	$150.00 copay	50% coinsurance	Pre-certification required for services. $250 penalty for non-compliance.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling SouthernScripts at 1-800-710-9341	Generic drugs Tier 1A Generic drugs Tier 1B Preferred brand drugs	$10 copay $30 copay $60 copay	N/A N/A N/A	Covers up to 30-day supply (retail prescription); 31-90 day supply (mail order prescription available). Generic drugs are mandatory. If brand dispensed when generic is available, you pay the difference.
	Non-preferred brand drugs	$80 copay	N/A	
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	Pre-certification required for services. $250 penalty for non-compliance.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	Pre-certification required for services. $250 penalty for non-compliance.
If you need immediate medical attention	Emergency room services	$150 copay	$150 copay	None
	Emergency medical transportation	$25 copay/visit	50% coinsurance / 20% coinsurance if emergency	None
	Urgent care	$50 copay/visit	$50 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Pre-certification required for services. $250 penalty for non-compliance.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	Pre-certification required for services. $250 penalty for non-compliance.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit	50% coinsurance	None
	Mental/Behavioral health inpatient services	0% coinsurance	50% coinsurance	None
	Substance use disorder outpatient services	$30 copay/visit	50% coinsurance	None
	Substance use disorder inpatient services	0% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No Charge	50% coinsurance	None
	Prenatal and postnatal care	$30 copay/visit	50% coinsurance	None
	Delivery and all inpatient services	0% coinsurance	50% coinsurance	Pre-certification required for extended stay. $250 penalty for non-compliance.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$45 copay/visit	50% coinsurance	Pre-certification required. $250 penalty for non-compliance. Check with plan for limitations that may apply based on type of therapy. Therapies included:60 combined visits for Cardiac and Pulmonary Rehabilitation, 30 combined visits for Occupational, Physical and Speech Therapy
	Physical/Speech/Occupational Therapy	$45 copay/visit	50% coinsurance	
	Skilled nursing care	0% coinsurance	50% coinsurance	Limited to 45 days per year, pre-certification required. $250 penalty for non-compliance.
	Durable medical equipment	0% coinsurance	50% coinsurance	Durable medical equipment includes medical supplies. Pre-certification required on all rentals greater than $500. $250 penalty for non-compliance.
	Hospice service	0% coinsurance	50% coinsurance	
If your child needs dental or eye care	Children's Eye exam	Not covered	Not covered	None
	Children's Glasses	Not covered	Not covered	
	Children's Dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic procedures
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal Convenience Items
- Experimental care
- Self-inflicted injuries

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Non-Surgical Podiatric Care	• Allergy Testing and Therapy	• IUD/IUD Insertions

Your Rights to Continue Coverage:

If you use coverage under the plan, then depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the COBRA administrator at 248-623-2816.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact**:** **www.claimchoice.com** or 800.221.4254.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,420
- **Patient pays** $120

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays (prescriptions)	$120
Coinsurance	$0
Limits or exclusions	$0
Total	**$120**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,100
- **Patient pays** $300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays (prescriptions)	$200
Coinsurance	$0
Limits or exclusions	$100
Total	**$300**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.