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 1-888-578-5555. 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.lpgov.org.com or call 1-888-578-5555 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750 / individual or $2,250/ family (Family deductible is Individual x 3 family members)	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. Preventive care and primary 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 other deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $4,250 individual / $12,750 family. There is no Out of Network Out of Pocket Limit	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?	Copayments for certain services, premiums, balance-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, Verity Health www.verityhealth.com	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	This plan does not require a referral to see a specialist

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	$15.00 copay/office visit no deductible	40% coinsurance	None
	Specialist visit	20% co-insurance, no deductible	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	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)	20% co-insurance	40% coinsurance	These test may require prior authorization, check with your plan to determine requirements, the penalty for no authorization is denial of the claim.
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% coinsurance	
If you need drugs to treat your illness or condition	Generic drugs	$20 copay/prescription retail & $40 copay mail order	Not Covered	Deductible does not apply Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Brand drugs	$35 copay/prescription retail & $70 copay mail order	Not Covered	
	Non-preferred brand drugs	$65 copay retail & $130 copay mail order	n/a	
	Specialty drugs	Same as Brand	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could denied
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization is required
If you need immediate medical attention	Emergency room care	$50.00 copay & 20% coinsurance, *deductible* does not apply	$50.00 copay & 20% coinsurance, *deductible* does not apply	None
	Emergency medical	20% coinsurance	20% coinsurance	

[* For more information about limitations and exceptions, see the plan or policy document at www.lpgov.org]

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)	
	transportation			
	Urgent care	$15 copay/visit, *deductible* does not apply	$15 copay/visit, *deductible* does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit, *deductible* does not apply and 20% coinsurance for other outpatient services	40% coinsurance	Inpatient mental health requires preauthorization, if you don't get preauthorization benefits could be denied.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be denied.
If your child needs	Children's eye exam	100%	Not covered	Coverage limited to one exam/year.

[* For more information about limitations and exceptions, see the plan or policy document at www.lpgov.org]

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)	
dental or eye care	Children's glasses	Not Covered	Not covered	
	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.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Weight loss programs

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: [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: CCMSI 1-888-578-5555.

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.

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

[* For more information about limitations and exceptions, see the plan or policy document at www.lpgov.org]

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** **$750**
- **Specialist copayment** **$0**
- **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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$2,390
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,390**

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$0**
- **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**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$750
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$750**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$0**
- **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**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$750
Copayments	$0
Coinsurance	$410
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,160**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert].
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.