
 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, www.lifetimebenefitsolutions.com or call the customer service number on your identification card. 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.com> or call the customer service number listed on your identification card to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Major medical: \$100 individual/ \$300 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. Preventive care , prescription drug coverage and Basic Benefits 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.
What is the out-of-pocket limit for this plan ?	Major medical: \$500 individual/ \$1,500 family; prescription drug coverage : \$6,100 individual/ \$11,700 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, 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 www.lifetimebenefitsolutions.com or call the customer service number listed on your identification card 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 (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	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/immunization	No charge	100% to allowed amount	Some out-of-network services may not be covered. 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 (x-ray, blood work)	No charge	100% to allowed amount	None
	Imaging (CT/PET scans, MRIs)	No charge	100% to allowed amount	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.proactrx.com	Generic drugs (Tier 1)	\$10 copay /prescription (retail & mail order)	Not covered	Note: Out-of-Network prescriptions are not covered. Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	\$20 copay /prescription(retail) \$40 copay /prescription(mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	\$35 copay /prescription(retail) \$70 copay /prescription(mail order)	Not covered	
	Specialty drugs	Up to \$50 copay per 30-day supply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	100% to allowed amount	None
	Physician/surgeon fees	No charge	100% to allowed amount	None
If you need immediate medical attention	Emergency room care	No charge	100% to allowed amount	None
	Emergency medical transportation	No charge	100% to allowed amount	
	Urgent care	No charge	100% to allowed amount	
If you have a hospital	Facility fee (e.g., hospital room)	No charge	100% to allowed amount	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)	
stay	Physician/surgeon fees	No charge	100% to allowed amount	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	None
	Inpatient services	No charge	100% to allowed amount	
If you are pregnant	Office visits	No charge	100% to allowed amount	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	100% to allowed amount	
	Childbirth/delivery facility services	No charge	100% to allowed amount	
If you need help recovering or have other special health needs	Home health care	No charge, first 40 visits under Basic Benefit. 20% coinsurance , 325 visit maximum under Major Medical Benefit.	100% to allowed amount , first 40 visits under Basic Benefit. 20% coinsurance , 325 visit maximum under Major Medical Benefit.	Limit: 365 visits/year
	Rehabilitation services	No charge if related to surgery or hospitalization; otherwise 20% coinsurance	100% to allowed amount if related to surgery or hospitalization; otherwise 20% coinsurance	Inpatient Limit: 365 days per disability (2 days in Skilled Nursing Facility count as 1 in Hospital), maximums are combined for Rehabilitation services , Habilitation services and Skilled nursing care .
	Habilitation services	No charge if related to surgery or hospitalization; otherwise 20% coinsurance	100% to allowed amount if related to surgery or hospitalization; otherwise 20% coinsurance	
	Skilled nursing care	No charge	100% to allowed amount	Limit: 365 days per disability (2 days in Skilled Nursing Facility count as 1 in Hospital), maximums are combined for Rehabilitation services , Habilitation services and Skilled nursing care .
	Durable medical equipment	20% coinsurance	20% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.

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)	
	Hospice services	No charge	20% coinsurance	Limit: 210 days per lifetime
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](#).)

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|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Hearing aids • Long-term care | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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| <ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care | <ul style="list-style-type: none"> • Infertility treatment • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private duty nursing |
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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: Department of 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](#). For more information about your rights, this notice, or assistance, contact: www.lifetimebenefitsolutions.com or the customer service number listed on your identification card. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Community Health Advocates, 633 Third Avenue, 10th Floor, New York, NY 10017, phone: (888) 614-5400, website: www.communityhealthadvocates.org, email: cha@cssny.org.

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 1-800-773-9529.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-773-9529.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-773-9529.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-773-9529.

—————*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](#) \$100
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 0%
- 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$40
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$240

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$00
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 0%
- 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$570
Coinsurance	\$560
<i>What isn't covered</i>	
Limits or exclusions	\$56
The total Joe would pay is	\$1,286

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$00
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 0%
- 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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$110
<i>What isn't covered</i>	
Limits or exclusions	\$00
The total Mia would pay is	\$210