**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 1-833-SANA-123. 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 http://www.healthcare.gov/sbc-glossary or call 1-800-444-3272 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $7,500 individual/ $15,000 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services are covered before you meet your deductible. Other services are covered but are subject to coinsurance, copayment, and/or 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | $7,500 individual/ $15,000 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, penalties for failure to obtain preauthorization for services, 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?** | Not Applicable | This plan does not use a provider network. You can receive covered services from any provider. |
| **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 |
|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 0% coinsurance | None |
| | Specialist visit | 0% coinsurance | Includes mental health office visits. |
| | Preventive care/screening/ immunization | No charge, deductible does not apply | 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) | 0% coinsurance | None. |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service. |
| **If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.sanabenefits.com** | Generic drugs | 0% coinsurance | Limited to a 90-day supply (retail or mail order) You pay copayment for each 30-day supply filled at retail and 90-day supply filled by mail order. |
| | Preferred brand drugs | 0% coinsurance | Limited to a 90-day supply (retail or mail order) You pay copayment for each 30-day supply filled at retail and 90-day supply filled by mail order. |
| | Non-preferred brand drugs | 0% coinsurance | Limited to a 90-day supply (retail or mail order) You pay copayment for each 30-day supply filled at retail and 90-day supply filled by mail order. |
| | Specialty drugs | 0% coinsurance | Limited to a 30-day supply (retail). |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service. |
| | Physician/surgeon fees | 0% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service. |
| **If you need immediate medical attention** | Emergency room care | 0% coinsurance | None. |
| | Emergency medical transportation | 0% coinsurance | None. |
| | Urgent care | 0% coinsurance | None. |

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|---|---|---|---|
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service. |
| | Physician/surgeon fees | 0% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service. |
| **If you need mental health, behavioral health, or substance abuse services** | Office Visits | 0% coinsurance | Includes marriage/family therapy/counseling and all psychiatry, psychology, and psychotherapy office visits. |
| | Other outpatient services | 0% coinsurance | Includes intensive outpatient programs and outpatient partial hospitalization programs. Preauthorization is required. Failure to obtain preauthorization may result in benefits reduced by 100% of the total cost of the service. |
| | Inpatient services | 0% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service. |
| **If you are pregnant** | Office visits | No charge, deductible does not apply | None |
| | Childbirth/delivery professional services | 0% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery facility services | 0% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| **If you need help recovering or have other special health needs** | Home health care | 0% coinsurance | Preauthorization is required. Failure to obtain preauthorization may result in benefits reduced by 100% of the total cost of the service. |
| | Rehabilitation services | 0% coinsurance | Preauthorization is required except for physical therapy, occupational therapy and massage therapy. Failure to obtain preauthorization may result in benefits reduced by 100%. Limited to 30 visits/treatment, 60 visits/year, except for speech therapy and applied behavioral analysis (ABA) therapy. |
| | Habilitation services | 0% coinsurance | Preauthorization is required except for physical therapy, occupational therapy and massage therapy. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service. |

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|---|---|---|---|
| | | | Limited to 30 visits per year for Occupational Therapy and Physical Therapy. |
| | Skilled nursing care | 0% coinsurance | Preauthorization is required. Failure to obtain preauthorization may result in benefits reduced by 100% of the total cost of the service.<br><br>Limited to 100 visits per member per calendar year. |
| | Durable medical equipment | 0% coinsurance | Preauthorization is required. Failure to obtain preauthorization may result in benefits reduced by 100% of the total cost of the service. |
| | Hospice services | 0% coinsurance | Preauthorization is required. Failure to obtain preauthorization may result in benefits reduced by 100% of the total cost of the service. |

**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 Care | • Long-Term Care | • Experimental Procedures |
| • Dental Care (Adult or Pediatric) | • Self-Inflicted | • Care When Traveling Outside the US |
| • Custodial Care | • Non-Surgical Care of The Foot | • Out-of-Network Pharmacies |
| • Foreign Travel | • Illegal Acts | • Routine Eye Care (Adult or Pediatric) |
| • Hypnosis | • Private Duty Nursing | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Chiropractic Care | • Acupuncture | • Infertility |
| • Massage Therapy | • Hearing Aids | • Spinal Fusion Procedures |

**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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. 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: 1-833-SANA-123

**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.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-SANA-123

## 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: $7,500
- Specialist copayment: $0
- Other copayment: $0
- Plan 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** | **$11,677** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $7,500 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,560** |

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible: $7,500
- Specialist copayment: $0
- Other copayment: $0
- Plan 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** | **$11,761** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $7,500 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$7,560** |

### Mia's Simple Fracture

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

- The plan's overall deductible: $7,500
- Specialist copayment: $0
- Other copayment: $0
- Plan 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** | **$2,338** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,338 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Mia would pay is** | **$2,398** |

* For more information about and exceptions, see the plan or policy document at www.sanabenefits.com