



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 ?	\$1,500 individual/ \$3,000 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	\$25 copayment , deductible does not apply	None
	Specialist visit	\$50 copayment , deductible does not apply	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)	30% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	30% 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	\$10 copayment – 30-day retail, \$20 copayment – 90 day mail order, deductible does not apply	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	\$30 copayment – 30-day retail, \$60 copayment – 90 day mail order, deductible does not apply	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	\$55 copayment – 30-day retail, \$110 copayment – 90 day mail order, deductible does not apply	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	\$200 copayment – 30-day retail, deductible does not apply	Limited to a 30-day supply (retail).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% 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	30% 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	\$500 copayment , deductible does not apply	Copay waived if admitted. If you receive services in addition to an emergency room care visit, additional deductible , or 30% coinsurance may apply e.g. surgery.
	Emergency medical transportation	30% coinsurance	None.
	Urgent care	\$50 copayment , deductible does not apply	If you receive services in addition to an urgent care visit, additional deductible , or 30% coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% 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	30% 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	\$50 copayment , deductible does not apply	Includes marriage/family therapy/counseling and all psychiatry, psychology, and psychotherapy office visits.
	Other outpatient services	30% 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	30% 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	30% 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	30% 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	30% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in benefits reduced by 100% of the total cost of the service.
	Rehabilitation services	\$25 copayment – physical and massage therapy visits, deductible	Preauthorization is required except for physical therapy, occupational therapy and massage therapy. Failure to obtain preauthorization may result in benefits reduced by 100%.

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

		does not apply, 30% coinsurance – all other therapy visits	Limited to 30 visits/treatment, 60 visits/year, except for speech therapy and applied behavioral analysis (ABA) therapy.
	Habilitation services	\$25 copayment – physical and massage therapy visits, deductible does not apply, 30% coinsurance – all other therapy visits	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. Limited to 30 visits per year for Occupational Therapy and Physical Therapy.
	Skilled nursing care	30% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in benefits reduced by 100% of the total cost of the service. Limited to 100 visits per member per calendar year.
	Durable medical equipment	30% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in benefits reduced by 100% of the total cost of the service.
	Hospice services	30% 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
- Dental Care (Adult or Pediatric)
- Custodial Care
- Foreign Travel
- Hypnosis
- Long-Term Care
- Self-Inflicted
- Non-Surgical Care of The Foot
- Illegal Acts
- Private Duty Nursing
- Experimental Procedures
- Care When Traveling Outside the US
- Out-of-Network Pharmacies
- Routine Eye Care (Adult or Pediatric)

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

- Chiropractic Care
- Massage Therapy
- Acupuncture
- Hearing Aids
- Infertility
- 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](#): \$1,500
- [Specialist](#) copayment: \$50
- Other [copayment](#): \$25
- Plan [coinsurance](#): 30%

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:	
<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$65
Coinsurance	\$5,056
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,681

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

- The [plan's](#) overall [deductible](#): \$1,500
- [Specialist](#) copayment: \$50
- Other [copayment](#): \$25
- Plan [coinsurance](#): 30%

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:	
<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$65
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,625

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

- The [plan's](#) overall [deductible](#): \$1,500
- [Specialist](#) copayment: \$50
- Other copayment: \$25
- Plan coinsurance: 30%

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:	
<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$65
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Mia would pay is	\$1,625

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