



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 844-676-4641. 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.dol.gov/ebsa/healthreform or call 844-676-4641 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: \$1,000/individual, \$3,000/family Out-of-network provider: \$5,000/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. The deductible is Embedded. 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. Deductible year runs 01/01 – 12/31
Are there services covered before you meet your deductible?	Yes. Preventive 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 care 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?	Yes. \$200/individual or \$400/family for prescription drug coverage . There are no other specific deductibles .	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?	Network providers: \$3,000/individual, \$9,000/family Out-of-network providers: \$12,700/individual, \$25,400/family	The out-of-pocket limit is the most you could pay in a year for covered services. The out-of-pocket limit is Embedded . 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 http://www.HabershamCountyBenefits.com or call 844-676-4641 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).
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	\$25 copayment	40% coinsurance	Deductible does not apply to copayment .
	Specialist visit	\$50 copayment	40% coinsurance	Deductible does not apply to copayment .
	Preventive care/screening/immunization	No charge	30% 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)	No charge	40% coinsurance	Labs in a clinic or independent lab setting are covered at no charge.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.HabershamCountyBenefits.com	Generic drugs	Select Pharmacy: \$5 copayment/Prescription Non-Select Pharmacy: \$20 copayment/Prescription		Cost sharing does not apply for preventive Prescriptions . Deductible does not apply to copayment for generic drugs only. Prescription deductible : \$200 /individual or \$400 /family Retail & Mail Order available up to a 90-day supply.
	Preferred brand drugs	Select Pharmacy: \$40 copayment/Prescription Non-Select Pharmacy: \$40 copayment/Prescription		
	Non-preferred Brand drugs	Select Pharmacy: \$75 copayment/Prescription Non-Select Pharmacy: \$75 copayment/Prescription		
	Specialty drugs	30-day supply Retail & Mail Order: Not Covered		None.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Outpatient Hospital: 20% coinsurance Ambulatory surgery center: \$150 Copay, then 20% coinsurance	40% coinsurance	Deductible does not apply to coinsurance to ambulatory surgery center. May require preauthorization .
	Physician/surgeon fees	Outpatient Hospital: 20% coinsurance Ambulatory surgery center: 20% coinsurance	40% coinsurance	Deductible does not apply to coinsurance to ambulatory surgery center.
If you need immediate medical attention	Emergency room care	\$150 copayment , then 20% coinsurance		Deductible does not apply to copayment .
	Emergency medical transportation	20% coinsurance		None.
	Urgent care	\$60 copayment	40% coinsurance	Deductible does not apply to copayment .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copayment	40% coinsurance	Deductible does not apply to copayment .
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required.
If you are pregnant	Office visits	No charge	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC.
	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	Visits: \$25 copayment	40% coinsurance	Preauthorization required. 120 visit limit/year
	Rehabilitation services	\$25 copayment	40% coinsurance	Deductible does not apply to copayment . Occupational Therapy: 20 visit limit/year.
	Habilitation services	\$25 copayment	40% coinsurance	Speech Therapy: 20 visit limit/year. Physical Therapy: 20 visit limit/year.
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization required. 60 days per year maximum
	Durable medical equipment	20% coinsurance	40% coinsurance	None.
	Hospice services	No charge	30% coinsurance	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	Limit of 1 routine exam per year.
	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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|------------------------|---------------------|--|
| • Cosmetic surgery | • Bariatric Surgery | • Long-term care |
| • Weight loss programs | • Acupuncture | • Non-emergency care when traveling outside the U.S. |
| • Dental Care (Adult) | | |

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

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| • Infertility Treatment (correction of physiological abnormalities) | • Emergency care when traveling outside the U.S. |
| • Routine Eye Care (one exam/year) | • Chiropractic Care |
| • Routine Foot Care | • Private Duty Nursing (inpatient only) |

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: : Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 844-676-4641

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-676-4641

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-676-4641

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 844-676-4641

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	\$1,000
■ Specialist Copayment	\$50
■ 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 test](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$2,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ Specialist Copayment	\$50
■ Hospital (facility) Coinsurance	20%
■ Other Coinsurance	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
[Diagnostic test](#) (*blood work*)
 Prescription drugs
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$900
Copayments	\$900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist Copayment	\$50
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$300
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500