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, go to www.geo-blue.com or by calling 1-855-282-3517. 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/ or call 1-855-282-3517 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Outside the U.S. – $0 individual/ $0 family. Inside the U.S., in Network – $0 individual/ $0 family. Inside the U.S., Out of Network - $1,000 individual/ $2,500 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 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	Outside the U.S., $0 individual/ $0 family. Inside U.S., in Network- $2,000 individual/ $5,000 family. Inside the U.S., Out of Network- $2,000 individual/ $5,000 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?	Copayments on certain services, premiums, balance-billing charges, deductibles, 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.geo-blue.com or call 1-855-282-3517 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
		Outside the U.S. Provider	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	No charge	$30 copay/visit	40% coinsurance; deductible does not apply	None
	Specialist visit	No charge	$30 copay/visit	40% coinsurance; deductible does not apply	20 visits per Policy Year for Chiropractic Care.
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance; 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)	No charge	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	40% coinsurance	Utilization review may apply.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.geo-blue.com	Generic drugs	$10 copay/ prescription per 30-day supply	$10 copay/ prescription per 30-day supply	$10 copay/ prescription per 30-day supply	Up to a 180-day supply available at participating provider. Mail order prescriptions available. Non-participating mail order pharmacy not covered. Deductible does not apply. Drug utilization review may apply.
	Preferred Brand-name drugs	$10 copay/ prescription per 30-day supply	$25 copay/ prescription per 30-day supply	$25 copay/ prescription per 30-day supply	
	Non preferred – Brand-name drugs	$10 copay/ prescription per 30-day supply	30% copay/ $150 Maximum copay per prescription per 30-day supply	30% copay/ $150 Maximum copay per prescription per 30-day supply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.geo-blue.com or call 1-855-282-3517.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Outside the U.S. Provider	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No charge	20% coinsurance	40% coinsurance	If an Insured Person requires emergency treatment of an Injury or Sickness and incurs covered expenses at a non-Preferred Provider, Covered Medical Expenses for the Emergency Medical Care rendered during the course of the emergency will be treated as if they had been incurred at a Preferred Provider.
	Emergency medical transportation	No charge	20% coinsurance	40% coinsurance	
	Urgent care	No charge	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	40% coinsurance	Utilization review may apply.
	Physician/surgeon fees	No charge	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$30 copay/visit	40% coinsurance; deductible does not apply	None
	Inpatient services	No charge	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	No charge	$30 copay/visit	40% coinsurance; deductible does not apply	Cost sharing does not apply for 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 professional services	No charge	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.geo-blue.com or call 1-855-282-3517.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Outside the U.S. Provider	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	40% coinsurance	120 visits/Policy Year
	Rehabilitation services	No charge	$30 copay/visit	40% coinsurance; deductible does not apply	30 visits/Policy Year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	No charge	$30 copay/visit	40% coinsurance; deductible does not apply	
	Skilled nursing care	No charge	20% coinsurance	40% coinsurance	120 days/Policy Year
	Durable medical equipment	No charge	20% coinsurance	40% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	20% coinsurance	40% coinsurance	Utilization review may apply.
If your child needs dental or eye care	Children's eye exam	No charge			One exam per 12 consecutive months. Deductible does not apply.
	Children's glasses	No charge			Limited to a combined $250 per 12 consecutive months for all vision lenses & frames. Deductible does not apply.
	Children's dental check-up	No charge			Limited to a combined $1,500 per Policy Year for all dental care. Deductible does not apply.

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
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

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
- Coverage provided outside the United States. See www.geo-blue.com
- Dental care (Adult & Children)
- Hearing aids (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (limitations apply)
- Routine eye care (Adult & Children)

* For more information about limitations and exceptions, see the plan or policy document at www.geo-blue.com or call 1-855-282-3517.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the insurer at 1-855-282-3517. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can contact: Customer Service at 1-855-282-3517.

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 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 1-855-282-3517.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-282-3517.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-282-3517.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-282-3517.

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.geo-blue.com or call 1-855-282-3517.

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	$0
Specialist cost sharing	$30
Hospital (facility) cost sharing	20%
Other cost sharing	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	$0
Copayments	$10
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,070**

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

The plan's overall deductible	$0
Specialist cost sharing	$30
Hospital (facility) cost sharing	20%
Other cost sharing	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	$0
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

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

The plan's overall deductible	$0
Specialist cost sharing	$30
Hospital (facility) cost sharing	20%
Other cost sharing	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	$0
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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

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