




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 844-302-7774. 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 844-302-7774 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|-----------------|---|
| What is the overall deductible ? | N/A | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | Not applicable. | This plan does not have a deductible . |
| Are there other deductibles for specific services? | Not applicable. | This plan does not have a deductible . |
| What is the out-of-pocket limit for this plan ? | Not applicable. | This plan does not have an out-of-pocket limit . |
| What is not included in the out-of-pocket limit ? | Not applicable. | This plan does not have an out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Not applicable. | This plan only covers preventive care. |
| Do you need a referral to see a specialist ? | Not applicable. | This plan only covers preventive care. |

 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 | Not Covered | | None |
| | Specialist visit | Not Covered | | None |
| | Preventive care/screening/immunization | 100% Covered | Not Covered | 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) | Not Covered | | None |
| | Imaging (CT/PET scans, MRIs) | Not Covered | | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at AnnaBananaBenefits.com | Generic drugs | Retail & Mail Order: No Charge | | Cost sharing does not apply for preventive Prescriptions . |
| | Preferred brand drugs | Retail & Mail Order: Not Covered | | |
| | Non-preferred brand drugs | Retail & Mail Order: Not Covered | | |
| | Specialty drugs | Retail & Mail Order: Not Covered | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Not Covered | | None |
| | Physician/surgeon fees | Not Covered | | None |
| If you need immediate medical attention | Emergency room care | Not Covered | | None |
| | Emergency medical transportation | Not Covered | | None |
| | Urgent care | Not Covered | | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Not Covered | | None |
| | Physician/surgeon fees | Not Covered | | None |

* For more information about limitations and exceptions, see the plan or policy document at [AnnaBananaBenefits.com](#).

| 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 need mental health, behavioral health, or substance abuse services | Outpatient services | Not Covered | | None. |
| | Inpatient services | Not Covered | | None. |
| If you are pregnant | Office visits | Not Covered | | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC. |
| | Childbirth/delivery professional services | Not Covered | | |
| | Childbirth/delivery facility services | Not Covered | | |
| If you need help recovering or have other special health needs | Home health care | Not Covered | | None |
| | Rehabilitation services | Not Covered | | None |
| | Habilitation services | Not Covered | | None |
| | Skilled nursing care | Not Covered | | None |
| | Durable medical equipment | Not Covered | | None |
| | Hospice services | Not Covered | | None |
| If your child needs dental or eye care | Children's eye exam | No Charge | Not Covered | Limit of 1 routine exam per year. |
| | Children's glasses | Not Covered | | None |
| | Children's dental check-up | 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](#).)

- Non-[Preventive care](#)

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

- [Preventive care](#)

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? No

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 844-302-7774

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-302-7774

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-302-7774

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 844-302-7774

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](#) N/A
- [Specialist](#) [*cost sharing*] N/A
- Hospital (facility) [*cost sharing*] 100%
- Other [*cost sharing*] 100%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|-----------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$12,700 |

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

- The [plan's](#) overall [deductible](#) N/A
- [Specialist](#) [*cost sharing*] N/A
- Hospital (facility) [*cost sharing*] 100%
- Other [*cost sharing*] 100%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$5,600 |

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

- The [plan's](#) overall [deductible](#) N/A
- [Specialist](#) [*cost sharing*] N/A
- Hospital (facility) [*cost sharing*] 100%
- Other [*cost sharing*] 100%

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,800 |