
 **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](http://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:
<b>What is the overall <u>deductible</u>?</b>	Outside the U.S. – \$0 individual/ \$0 family. Inside the U.S., <u>in Network</u> – \$0 individual/ \$0 family. Inside the U.S., <u>Out of Network</u> - \$0 individual/ \$0 family.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. This <u>plan</u> does not have a <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Outside the U.S., \$1,000 individual/ \$2,500 family. Inside U.S., <u>in Network</u> - \$1,000 individual/ \$2,500 family. Inside the U.S., <u>Out of Network</u> - \$1,000 individual/ \$2,500 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Copayments</u> on certain services, <u>premiums</u> , <u>balance-billing</u> charges, deductibles, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.geo-blue.com">www.geo-blue.com</a> or call 1-855-282-3517 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

**Questions:** Call 1-855-282-3517 or visit us at [www.geo-blue.com](http://www.geo-blue.com). If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.geo-blue.com](http://www.geo-blue.com) or call 1-855-282-3517 to request a copy.

 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	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	No charge; <a href="#">deductible</a> does not apply	10% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (X-ray, blood work)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Utilization review may apply.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.geo-blue.com">www.geo-blue.com</a>	Generic drugs	10% <a href="#">copay</a> /prescription per 30-day supply	10% <a href="#">copay</a> /prescription per 30-day supply	10% <a href="#">copay</a> /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.  Drug utilization review may apply.
	Preferred Brand-name drugs	10% <a href="#">copay</a> /prescription per 30-day supply	10% <a href="#">copay</a> /prescription per 30-day supply	10% <a href="#">copay</a> /prescription per 30-day supply	
	Non preferred – Brand-name drugs	10% <a href="#">copay</a> /prescription per 30-day supply	30% <a href="#">copay</a> / \$150 Maximum copay per prescription per 30-day supply	30% <a href="#">copay</a> / \$150 Maximum copay per prescription per 30-day supply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.geo-blue.com](http://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	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	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.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Utilization review may apply.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
	Inpatient services	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	

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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	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Utilization review may apply.
If your child needs dental or eye care	Children's eye exam	Not covered			Not covered
	Children's glasses	Not covered			Not covered
	Children's dental check-up	Not covered			Not covered

### Excluded Services & Other Covered Services:

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Children)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Routine eye care (Adult &amp; Children)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture (if prescribed for rehabilitation purposes)</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Coverage provided outside the United States. See <a href="http://www.geo-blue.com">www.geo-blue.com</a></li> <li>• Hearing aids (limitations apply)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing (limitations apply)</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.geo-blue.com](http://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](http://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](http://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](http://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, kwijigo holne' 1-855-282-3517.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist cost sharing</a>	10%
■ Hospital (facility) <a href="#">cost sharing</a>	10%
■ Other <a href="#">cost sharing</a>	10%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,060</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist cost sharing</a>	10%
■ Hospital (facility) <a href="#">cost sharing</a>	10%
■ Other <a href="#">cost sharing</a>	10%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$500
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$520</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist cost sharing</a>	10%
■ Hospital (facility) <a href="#">cost sharing</a>	10%
■ Other <a href="#">cost sharing</a>	10%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$300</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.geo-blue.com](http://www.geo-blue.com) or call 1-855-282-3517.