
 **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 - \$0 individual/ \$0 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. This plan does not have a 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., \$1,000 individual/ \$2,500 family. Inside U.S., in Network - \$1,000 individual/ \$2,500 family. Inside the U.S., Out of Network - \$1,000 individual/ \$2,500 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 .

Questions: Call 1-855-282-3517 or visit us at 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 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% coinsurance	10% coinsurance	10% coinsurance	None
	Specialist visit	10% coinsurance	10% coinsurance	10% coinsurance	None
	Preventive care/screening/immunization	No charge; deductible does not apply	No charge; deductible does not apply	10% coinsurance	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)	10% coinsurance	10% coinsurance	10% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	10% coinsurance	10% 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. Drug utilization review may apply.
	Preferred Brand-name drugs	10% copay /prescription per 30-day supply	10% copay /prescription per 30-day supply	10% 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)	10% coinsurance	10% coinsurance	10% coinsurance	None
	Physician/surgeon fees	10% coinsurance	10% coinsurance	10% 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	10% coinsurance	10% coinsurance	10% 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	10% coinsurance	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	10% coinsurance	10% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	10% coinsurance	Utilization review may apply.
	Physician/surgeon fees	10% coinsurance	10% coinsurance	10% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	10% coinsurance	10% coinsurance	None
	Inpatient services	10% coinsurance	10% coinsurance	10% coinsurance	
If you are pregnant	Office visits	10% coinsurance	10% coinsurance	10% coinsurance	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	10% coinsurance	10% coinsurance	10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	10% coinsurance	10% coinsurance	

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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	Home health care	10% coinsurance	10% coinsurance	10% coinsurance	Utilization review may apply.
	Rehabilitation services	10% coinsurance	10% coinsurance	10% coinsurance	Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	10% coinsurance	10% coinsurance	10% coinsurance	
	Skilled nursing care	10% coinsurance	10% coinsurance	10% coinsurance	Private Duty Nursing is limited to 40 visits per calendar year or continuous twelve-month period
	Durable medical equipment	10% coinsurance	10% coinsurance	10% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	10% coinsurance	10% coinsurance	10% coinsurance	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:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult & Children) 	<ul style="list-style-type: none"> • Long-term care • Routine eye care (Adult & Children) 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Acupuncture (if prescribed for rehabilitation purposes) • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Coverage provided outside the United States. See www.geo-blue.com • Hearing aids (limitations apply) 	<ul style="list-style-type: none"> • Infertility treatment • Non-emergency care when traveling outside the U.S. • Private-duty nursing (limitations apply)

* 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, 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 plan's overall deductible	\$0
■ Specialist cost sharing	10%
■ Hospital (facility) cost sharing	10%
■ Other cost sharing	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*)

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

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

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	10%
■ Hospital (facility) cost sharing	10%
■ Other cost sharing	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*)

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

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$520

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist cost sharing	10%
■ Hospital (facility) cost sharing	10%
■ Other cost sharing	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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

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

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

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