




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, [www.acuity-grp.com](http://www.acuity-grp.com) or 1-866-308-4047. 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.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-888-866-5311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$1,000 individual / \$2,000 family. Copayments do not count towards reaching your annual deductible.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductible</a> specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$4,000 individual / \$8,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, prior authorization/cost containment penalties, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Not Applicable.	This <a href="#">plan</a> does not use a provider <a href="#">network</a> . You are encouraged to submit a Provider Nomination to ClaimDOC before your first appointment so they may educate your provider.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
If you visit a health care <a href="#">provider's office</a> or <a href="#">clinic</a>	Primary care visit to treat an injury or illness	\$30 <a href="#">copayment</a> /office visit	Includes x-rays, tests, inoculations, lab work performed in the provider's office at the time of the appointment. Does not include MRIs, other non-X-ray imaging test, surgery, or chemotherapy.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a> /office visit	DPC referral required. Includes x-rays, tests, inoculations, lab work performed in the provider's office at the time of the appointment. Does not include MRIs, other non-X-ray imaging test, surgery, or chemotherapy.
	<a href="#">Preventive care/screening</a> /immunization	No charge	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. Frequency limits apply.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	
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.truescripts.com">www.truescripts.com</a> or 1-844-257-1955.	Generic drugs	\$25 <a href="#">copayment</a> for up to 30-day supply; \$50 <a href="#">copayment</a> for up to 90-day supply through mail order pharmacy	<a href="#">Preauthorization</a> is required for Specialty medications
	Preferred brand drugs	\$50 <a href="#">copayment</a> for up to 30-day supply; \$100 <a href="#">copayment</a> for up to 90-day supply through mail order pharmacy	
	Non-preferred brand drugs	\$75 <a href="#">copayment</a> for up to 30-day supply; \$150 <a href="#">copayment</a> for up to 90-day supply through mail order pharmacy	
	<a href="#">Specialty drugs</a>	\$75 <a href="#">copayment</a> for up to 30-day supply	

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.acuity-grp.com](http://www.acuity-grp.com).]

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <a href="#">copayment</a> applies, then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service.
	Physician/surgeon fees	\$250 <a href="#">copayment</a> applies, then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copayment</a> applies, then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required within 48 hours, if admitted as an inpatient. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	Non-emergency transport requires <a href="#">Preauthorization</a> . If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service. Only covered if a "prudent" layperson would consider usage appropriate.
	<a href="#">Urgent care</a>	\$75 <a href="#">copayment</a>	Includes routine services (X-rays, surgery, etc.) performed on the same day by same provider. If sent to the ER from Urgent Care, Urgent Care <a href="#">copayment</a> is waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <a href="#">copayment</a> , then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service.
	Physician/surgeon fees	\$500 <a href="#">copayment</a> , then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$250 <a href="#">copayment</a> , then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service.
	Inpatient services	\$500 <a href="#">copayment</a> , then 20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service.

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Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
<b>If you are pregnant</b>	Office visits	\$30 <a href="#">copayment</a> /office visit	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service. Maternity Benefits are not covered for enrolled dependent children.
	Childbirth/delivery professional services	\$500 <a href="#">copayment</a> , then 20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$500 <a href="#">copayment</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service.
	<a href="#">Rehabilitation services</a>	If office-based, \$0 <a href="#">copayment</a> for first 12 visits during the Plan Year; thereafter, \$30 <a href="#">copayment</a> .  If hospital-based, deductible applies until met, then 20% <a href="#">coinsurance</a>	Up to 60 maximum visits per Plan Year
	<a href="#">Habilitation services</a>	\$50 <a href="#">copayment</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service. 30 maximum visits per Plan Year.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required if charges are greater than \$500. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service.
	<a href="#">Hospice services</a>	No charge	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits will be reduced to 50% of the total cost of the service.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	N/A
	Children's glasses	Not covered	N/A
	Children's dental check-up	Not covered	N/A

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.acuity-grp.com](http://www.acuity-grp.com).]

## 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](#).)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Infertility treatment
- Private-duty nursing
- Routine foot 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: 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 more information about your rights, this notice, or assistance, contact: the plan sponsor at 1-914-241-4999 or the plan's Claims processor at 1-866-308-4047, or the U. S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://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 1-866-308-4047.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-308-4047.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-308-4047.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-308-4047.]

*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 pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist \[cost sharing\]](#) \$50
- 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*)

<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>	\$1,000
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$1,900
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,460</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist \[cost sharing\]](#) \$50
- 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*)

<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>	\$1,000
<a href="#">Copayments</a>	\$1,300
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,420</b>

### Mia's Simple Fracture

(emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist \[cost sharing\]](#) \$50
- 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*)

<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>	\$1,000
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>

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