



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, visit www.LuminareHealth.com. 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 1-866-280-4120 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network provider : \$0/individual or \$0/family per calendar year. Out-of-network provider : Not applicable.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	No.	You will not have to meet a deductible before the plan pays for any services.
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 ?	Network provider : \$2,000/individual or \$4,000/family per calendar year. Out-of-network provider : Not applicable.	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 ?	Penalties for failure to obtain preauthorization for services, premiums , balance-billing charges, 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.anthem.com/ca or call 1-866-280-4120 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 copay /visit	Not covered	None.
	Specialist visit	\$30 copay /visit	Not covered	None.
	Preventive care/screening/immunization	\$0 copay /visit	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)	\$0 copay /test	Not covered	None.
	Imaging (CT/PET scans, MRIs)	\$100 copay /test	Not covered	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.empirxhealth.com or call 1-877-669-0410.	Generic drugs (Tier 1)	Retail: \$10 copay /prescription Mail order & Retail90: \$20 copay /prescription	Retail: \$10 copay /prescription Mail order & Retail90: \$20 copay /prescription	Female oral contraceptives (generic) have no copay for retail & mail order. Copay applies up to a 34-day supply Retail or 35-90 day supply Mail Order or Retail90 prescription.
	Preferred brand drugs (Tier 2)	Retail: \$30 copay /prescription Mail order & Retail90: \$60 copay /prescription	Retail: \$30 copay /prescription Mail order & Retail90: \$60 copay /prescription	Copay applies up to a 34-day supply Retail or 35-90 day supply Mail Order or Retail90 prescription.
	Non-preferred brand drugs (Tier 3)	Retail: \$60 copay /prescription Mail order & Retail90: \$120 copay /prescription	Retail: \$60 copay /prescription Mail order & Retail90: \$120 copay /prescription	Copay applies up to a 34-day supply Retail or 35-90 day supply Mail Order or Retail90 prescription.
	Specialty drugs (Tier 4)	Subject to the applicable Generic, Preferred, and Non-preferred copays listed above	Not covered	Copay applies up to a 34-90 day supply.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 copay	Not covered	Preauthorization may be required.
	Physician/surgeon fees	\$0 copay	Not covered	None.
If you need immediate medical attention	Emergency room care	\$200 copay /visit		Copay waived if admitted, including if admitted for observation.
	Emergency medical transportation	\$0 copay		Preauthorization is required for air ambulance and ground non-emergency.
	Urgent care	\$30 copay /visit		None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 copay	Not covered	Preauthorization is required.
	Physician/surgeon fees	\$0 copay	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay /visit Facility: No cost sharing	Not covered	Preauthorization is required, including for residential, partial hospitalization and intensive outpatient.
	Inpatient services	\$0 copay	Not covered	Preauthorization is required.

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 are pregnant	Office visits	\$30 copay /visit	Not covered	Preauthorization is required if stay exceeds 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section. Cost sharing does not apply for preventive services. Depending on the type of services, a copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	\$0 copay	Not covered	
	Childbirth/delivery facility services	\$150 copay	Not covered	
If you need help recovering or have other special health needs	Home health care	\$30 copay /visit	Not covered	Preauthorization is required. Preauthorization is required for home infusion. Limited to 100 visits per calendar year. A periodic visit by either a nurse or therapist, or up to 4 hours of home health care services.
	Rehabilitation services	\$30 copay /visit	Not covered	Limited to 52 visits per calendar year; combined with acupuncture, chiropractic, and physical therapy. Occupational therapy, speech therapy, and cardiac rehabilitation visits are not limited. This restriction does not apply in circumstances of treatment for ABA recognized therapies.
	Habilitation services	\$30 copay /visit	Not covered	Limited to 52 visits per calendar year; combined with acupuncture, chiropractic, and physical therapy. Occupational therapy, speech therapy, and cardiac rehabilitation visits are not limited. This restriction does not apply in circumstances of treatment for ABA recognized therapies.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.LuminareHealth.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)	
	Skilled nursing care	\$0 copay	Not covered	Preauthorization is required. Limited to 100 days per calendar year.
	Durable medical equipment	\$0 copay	Not covered	Preauthorization is required for each durable medical equipment purchase over \$1,500 and durable medical equipment rental over \$500 a month.
	Hospice services	\$0 copay	Not covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None.
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	Not covered	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](#).)

- Cosmetic surgery
- Dental care (Child, Adult)
- Infertility treatment (except for diagnostic testing)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye 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 (Limited to 52 combined maximum visit with chiropractic care & physical therapy)
- Bariatric surgery
- Chiropractic care (Limited to 52 combined maximum visits with acupuncture & physical therapy)
- Cochlear implant
- Hearing aids (Limited to one hearing aid per ear every 3 years)

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 more information about your rights, this notice, or assistance, contact: Luminare Health Benefits, Inc. by calling 1-866-280-4120 or the 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? 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 1-866-280-4120.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-280-4120.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-280-4120.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-866-280-4120 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-280-4120.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-280-4120.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-280-4120.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-280-4120.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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 copayment	\$30
■ Hospital (facility) copayment	\$150
■ Other copayment	\$30

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	\$160
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$220

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 copayment	\$30
■ Hospital (facility) copayment	\$0
■ Other copayment	\$30

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	\$1,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,220

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$30
■ Hospital (facility) copayment	\$200
■ Other copayment	\$30

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	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$400

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



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, visit www.LuminareHealth.com. 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 1-866-280-4120 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network provider : \$350/individual or \$1,400/family per calendar year. Out-of-network provider : \$500/individual or \$2,000/family per calendar year.	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. The following services by a network provider : Preventive care .	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 ?	Network provider : \$1,600/individual or \$6,400/family per calendar year. Out-of-network provider : \$5,600/individual or \$22,400/family per calendar year. Prescription drugs maximum: \$5,125/Individual or \$7,300/family per calendar year.	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 ?	Penalties for failure to obtain preauthorization for services, premiums , balance-billing charges, 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.anthem.com/ca or call 1-866-280-4120 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
		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	40% coinsurance	None.
	Specialist visit	10% coinsurance	40% coinsurance	None.
	Preventive care/screening/immunization	No charge	40% coinsurance	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)	10% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.empirxhealth.com or call 1-877-669-0410.	Generic drugs (Tier 1)	Retail: \$10 copay /prescription Mail order & Retail90: \$20 copay /prescription	Retail: \$10 copay /prescription Mail order & Retail90: \$20 copay /prescription	Female oral contraceptives (generic) have no copay for retail & mail order. Covers up to a 34 day supply (retail) or 90 day supply (mail order or Retail90).
	Preferred brand drugs (Tier 2)	Retail: \$30 copay /prescription Mail order & Retail90: \$60 copay /prescription	Retail: \$30 copay /prescription Mail order & Retail90: \$60 copay /prescription	Covers up to a 34-day supply (retail prescription); 35-90 day supply (mail order prescription or Retail90).
	Non-preferred brand drugs (Tier 3)	Retail: \$60 copay /prescription Mail order & Retail90: \$120 copay /prescription	Retail: \$60 copay /prescription Mail order & Retail90: \$120 copay /prescription	Covers up to a 34-day supply (retail subscription); 35-90 day supply (mail order prescription or Retail90).
	Specialty drugs (Tier 4)	Subject to the applicable Generic, Preferred, and Non-preferred copays listed above	Not covered	Covers up to a 34-90 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Preauthorization may be required.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.LuminareHealth.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)	
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	\$100 copay /visit and then 10% coinsurance		Copay waived if admitted, including if admitted for observation.
	Emergency medical transportation	10% coinsurance		Preauthorization is required for air ambulance and ground non-emergency.
	Urgent care	10% coinsurance		None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	40% coinsurance	Preauthorization is required, including for residential, partial hospitalization and intensive outpatient.
	Inpatient services	10% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	10% coinsurance	40% coinsurance	Preauthorization is required if stay exceeds 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section. Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance and deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	

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 help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Preauthorization is required. Preauthorization is required for home infusion. A periodic visit by either a nurse or therapist, or up to 4 hours of home health care services.
	Rehabilitation services	10% coinsurance	40% coinsurance	Limited to 52 visits per calendar year for chiropractic. Limited to 52 visits per calendar year for acupuncture. No out-of-network provider benefits for acupuncture, chiropractic care and physical therapy.
	Habilitation services	10% coinsurance	40% coinsurance	Limited to 52 visits per calendar year for chiropractic. Limited to 52 visits per calendar year for acupuncture. No out-of-network provider benefits for acupuncture, chiropractic care and physical therapy.
	Skilled nursing care	10% coinsurance	40% coinsurance	Preauthorization is required. Limited to 100 days per calendar year.
	Durable medical equipment	10% coinsurance	40% coinsurance	Preauthorization is required for each durable medical equipment purchase over \$1,500 and durable medical equipment rental over \$500 a month.
	Hospice services	10% coinsurance	40% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None.
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	Not covered	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](#).)

- | | | |
|---|--|--|
| • Acupuncture – Out-of-network provider | • Infertility treatment | • Physical therapy – Out-of-network provider |
| • Chiropractic care – Out-of-network provider | • Long term care | • Routine eye care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot Care |
| • Dental care (Child, Adult) | | |

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

- | | | |
|--|--|--|
| • Acupuncture – Network providers only | • Chiropractic care – Network providers only | • Hearing aids (Limited to one hearing aid per ear per year) |
| • Bariatric surgery | • Cochlear implant | • Private duty nursing (outpatient only) |

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 more information about your rights, this notice, or assistance, contact: Luminare Health Benefits, Inc. by calling 1-866-280-4120 or the 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? 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 1-866-280-4120.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-280-4120.

Navajo (Dine): Dine'ek'ehgo shika at'ohwol ninsingo, kwijigo holne' 1-866-280-4120.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-866-280-4120 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-280-4120.

Samoa (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-280-4120.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-280-4120.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-866-280-4120.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	\$350
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$10
Coinsurance	\$1,200

<i>What isn't covered</i>	
Limits or exclusions	\$60

The total Peg would pay is	\$1,620
-----------------------------------	----------------

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$350
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$900
Coinsurance	\$200

<i>What isn't covered</i>	
Limits or exclusions	\$20

The total Joe would pay is	\$1,470
-----------------------------------	----------------

Mia's Simple Fracture

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

■ The plan's overall deductible	\$350
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	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
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$100
Coinsurance	\$200

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$650
-----------------------------------	--------------

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