> ⚠️ 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, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. Call 1-866-815-6001 to request a copy.

Important Questions	Guardian Network	Health Smart Network	Out of Network	Why This Matters:
What is the overall deductible?	$3,000 / $6,000	$3,000 / $6,000	$4,500 / $9,000	Generally, you must pay all 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. **Preventive care** services are covered before you meet your **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 your deductible for certain services.
What is the out-of-pocket limit for this plan?	$6,000 / $12,000	$6,000 / $12,000	$15,000 / $20,000	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?	**Premiums, balanced-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			You will pay less if you see an in-network provider.
Do you need a referral to see a specialist?	Yes			Virtual Primary Care Referral
Coinsurance	70% / 30%	70% / 30%	60% / 40%	Plan covers 70% in network & 60% out of network. Member responsibility is 30% in network & 40% out of network.

⚠️ 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
		Guardian Network	**Health Smart Network**	**Out of Network**	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 Copay with Virtual Primary Care Referral	$55 Copay without Virtual Primary Care Referral	Deductible & 40% Coinsurance	
	Specialist visit	$0 Copay with Virtual Primary Care Referral	$75 Copay without Virtual Primary Care Referral	Deductible & 40% Coinsurance	
	Preventive care/screening/ immunization	Plan pays 100% of Plan Allowable	Plan pays 100% of Plan Allowable	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	Deductible & then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible & 40% Coinsurance	
	Imaging (CT/PET scans, MRIs)	Deductible & then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible & 40% Coinsurance	
If you need drugs to treat your illness or condition	Generic drugs	$10 Copayment - 30 Day Supply		Not Covered	Ventegra Generic Plus Only Formulary Necessary Brands through ScriptAide Patient Application Program for Specialty Medications. Medications that are not on the formulary. *There are financial requirements.
	Preferred brand drugs	Not Covered			
	Non-preferred brand drugs	Not Covered			
	Specialty drugs	Not Covered			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible & then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible & 40% Coinsurance	
	Physician/Surgeon fees	Deductible & then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible & 40% Coinsurance	

[* For more information about limitations and exceptions, see the plan or policy document.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Guardian Network	Health Smart Network	Out of Network	
If you need immediate medical attention	[Emergency room care](#)	Deductible then 30% Coinsurance	Deductible & then 30% Coinsurance	Deductible then 40% Coinsurance	
	[Emergency medical transportation](#)	Deductible then 30% Coinsurance	Deductible & then 30% Coinsurance	Deductible then 40% Coinsurance	
	[Urgent care](#)	$0 Copay with Virtual Primary Care Referral	$75 Copay without Virtual Primary Care Referral	Deductible & 40% Coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible then 40% Coinsurance	
	Physician/surgeon fees	Deductible then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible then 40% Coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible & then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible & 40% Coinsurance	
	Inpatient services	Deductible & then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible & 40% Coinsurance	
If you are pregnant	Office visits	$0 Copayment	$0 Copayment	Deductible & 40% Coinsurance	Service frequency based on ACA guidelines.
	Childbirth/delivery professional services	Deductible then 30% Coinsurance	Deductible & then 30% Coinsurance	Deductible then 40% Coinsurance	
	Childbirth/delivery facility services	Deductible then 30% Coinsurance	Deductible & then 30% Coinsurance	Deductible then 40% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Guardian Network	**Health Smart Network**	**Out of Network**	
If you need help recovering or have other special health needs	Home health care	Deductible & then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible & 40% Coinsurance	
	Rehabilitation services	Deductible & then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible & 40% Coinsurance	Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehab (Max 25 visits each) Spinal Manipulation (Max 15 Visits) Spinal Manipulation – $50 Copay
	Habilitation services	Deductible & then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible & 40% Coinsurance	
	Skilled nursing care	Deductible & then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible & 40% Coinsurance	Paid at semiprivate room rate - Maximum of 60 days
	Durable medical equipment	Deductible & then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible & 40% Coinsurance	Limited to 12-month rental or purchase price, whichever is less Over $500 Requires Precert
	Hospice services	Deductible & then 30% Coinsurance - Virtual Primary Care Referral Required	Deductible & then 30% Coinsurance	Deductible & 40% Coinsurance	
If your child needs dental or eye care	Children's eye exam	Not Covered			
	Children's glasses	Not Covered			
	Children's dental check-up	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**.)		
• Acupuncture	• Infertility Treatments	• Private-Duty Nursing
• Bariatric Surgery	• Long Term Care	• Routine Foot Care
• Cosmetic Surgery	• Non-Emergency Care When Traveling outside the U.S.	• Weight Loss Programs
• Dental Care (Adult)		
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Durable Medical Equipment	• Chiropractic 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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

[* For more information about limitations and exceptions, see the plan or policy document.]

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)	Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)

Peg is Having a Baby

- The **plan's** overall **deductible** — $3,000
- **Specialist** [*cost sharing*] — $0
- Hospital (facility) [*cost sharing*] — 30%
- Other [*cost sharing*] — 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:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$3,810
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$6,810**

Managing Joe's Type 2 Diabetes

- The **plan's** overall **deductible** — $3,000
- **Specialist** [*cost sharing*] — $0
- Hospital (facility) [*cost sharing*] — 30%
- Other [*cost sharing*] — 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:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,600**

Mia's Simple Fracture

- The **plan's** overall **deductible** — $3,000
- **Specialist** [*cost sharing*] — $0
- Hospital (facility) [*cost sharing*] — 30%
- Other [*cost sharing*] — 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:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.