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, call 1-800-336-0123 or visit www.hometownhealth.comand sign into the Member Portal. 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.healthcare.gov/sbc-glossary or call 1-800-336-0123 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: $500/Individual, $1,000/Family Out of Network: $2,000/Individual, $4,000/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 the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care/screening/immunization, Emergency room care, Emergency medical transportation, Office visits, Prescription drug coverage does not apply towards the deductible.	This plan covers some items and services even if you haven't yet met the annual 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?	Yes.**$0** per person for prescription drugs There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**In Network:** $2,000/Individual, $4,000/Family **Out of Network:** $4,000/Individual, $8,000/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?	Premiums, balance-billing charges, and health care this plan does not 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.hometownhealth.com or call 1-800-336-0123 for a list of network provider.	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
		In Network (You will pay the least)	Out of Network (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.	$15 Copayment/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance	None
	Specialist visit	$30 Copayment/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance	Prior authorization required for plastic surgery and genetic counseling services.
	Preventive care/screening/immunization	No Charge	Subject to deductible, then 30% 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)	X-ray: $30 Copayment/Visit, Deductible does not apply Blood work: $0 Copayment/Visit, Deductible does not apply	X-ray: Subject to deductible, then 30% Coinsurance Blood work: Subject to deductible, then 30% Coinsurance	General laboratory services unless covered under ACA preventive guidelines.
	Imaging (CT/PET scans, MRIs)	$50 Copayment/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Tier 1 (Generic drugs)	Retail: $10 Copayment, Deductible does not apply Mail order: $20 Copayment, Deductible does not apply	Retail: Not Covered Mail order: Not Covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Tier 2 (Preferred Drugs)	Retail: $30 Copayment, Deductible does not apply Mail order: $60 Copayment, Deductible does not apply	Retail: Not Covered Mail order: Not Covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
	Tier 3 (Non Preferred Drugs)	Retail: $60 Copayment, Deductible does not apply Mail order: $120 Copayment, Deductible does not apply	Retail: Not Covered Mail order: Not Covered	
	Specialty drugs	Retail: 30% Coinsurance, Deductible does not apply Mail order: 30% Coinsurance, Deductible does not apply	Retail: Not Covered Mail order: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 Copayment/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance	Prior Authorization required. Does not apply to specialty drugs obtained at the hospital or physician's office.
	Physician/surgeon fees	$250 Copayment/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance	Prior Authorization required.
If you need immediate medical attention	Emergency room care	$100 Copayment/Visit, Deductible does not apply	$100 Copayment/Visit, Deductible does not apply	None
	Emergency medical transportation	$100 Copayment/Visit, Deductible does not apply	$100 Copayment/Visit, Deductible does not apply	None
	Urgent care	$15 Copayment/Visit, Deductible does not apply	$15 Copayment/Visit, Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Subject to deductible, then 10% Coinsurance	Subject to deductible, then 30% Coinsurance	Prior Authorization required.
	Physician/surgeon fees	$250 Copayment/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance	Prior Authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 Copayment/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance	Intensive outpatient, partial hospitalization and office visits that are a part of a substance abuse treatment program require Prior Authorization.
	Inpatient services	Subject to deductible, then 10% Coinsurance	Subject to deductible, then 30% Coinsurance	Prior Authorization required.
If you are pregnant	Office Visits	No Charge	Subject to deductible, then 30% Coinsurance	Depending on the type of services, a cost share may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Prior approval required for coverage if inpatient stay exceeds federally established minimum time frames. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	$250 Copayment/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance	
	Childbirth/delivery facility services	Subject to deductible, then 10% Coinsurance	Subject to deductible, then 30% Coinsurance	
If you need help recovering or have other special health needs	Home health care	$30 Copayment/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance	None
	Rehabilitation services	$15 Copayment/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance	120 visit(s) per year.Includes physical therapy, speech therapy and occupational therapy.
	Habilitation services	$15 Copayment/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance	120 visit(s) per year
	Skilled nursing care	Subject to deductible, then 10% Coinsurance	Subject to deductible, then 30% Coinsurance	100 days per year
	Durable medical equipment	Subject to deductible, then 10% Coinsurance	Subject to deductible, then 30% Coinsurance	1 item(s) per 3 years
	Hospice Services	$30 Copayment/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance	5 days per episode

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	Subject to deductible, then 30% Coinsurance	1 exam(s) per year Routine exams limited to one per calendar year.
	Children's glasses	Not Covered	Not Covered	1 item(s) per year Coverage limited to one pair of glasses/year.
	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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye exam for Adult
- Routine foot care
- Weight loss programs

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 options to continue coverage are 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 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? Not Applicable

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 [800-336-0123].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [800-336-0123].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [800-336-0123].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [800-336-0123].]

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	$500
Specialist copayment	$30
Hospital (facility) coinsurance	Not Applicable
Other copayment	$15

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	$500
Copayments	$100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,400**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	Not Applicable
Other copayment	$15

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	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,300**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	Not Applicable
Other copayment	$15

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	$200
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs.For more information about the wellness program, please contact:

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