



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.com and 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: \$5,000/Individual, \$10,000/Family Out of Network: \$10,000/Individual, \$20,000/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 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, 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: \$5,000/Individual, \$10,000/Family Out of Network: \$10,000/Individual, \$20,000/Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on 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.	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	None
	Specialist visit	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	Prior authorization required for plastic surgery and genetic counseling services.
	Preventive care/screening /immunization	No Charge	Subject to deductible, then 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)	X-ray: Subject to deductible, then 0% Coinsurance Blood work: Subject to deductible, then 0% Coinsurance	X-Ray: Subject to deductible, then 40% Coinsurance Blood work: Subject to deductible, then 40% Coinsurance	General laboratory services unless covered under ACA preventive guidelines.
	Imaging (CT/PET scans, MRIs)	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% 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: Subject to deductible, then 0% Coinsurance Mail order: Subject to deductible, then 0% Coinsurance	Not Covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Tier 2 (Preferred Drugs)	Retail: Subject to deductible, then 0% Coinsurance Mail order: Subject to deductible, then 0% Coinsurance	Not Covered	

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: Subject to deductible, then 0% Coinsurance Mail order: Subject to deductible, then 0% Coinsurance	Not Covered	
	Specialty drugs	Retail: Subject to deductible, then 0% Coinsurance Mail order: Subject to deductible, then 0% Coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	Prior Authorization required. Does not apply to specialty drugs obtained at the hospital or physician's office.
	Physician/surgeon fees	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	Prior Authorization required.
If you need immediate medical attention	Emergency room care	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	None
	Emergency medical transportation	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	None
	Urgent care	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	Prior Authorization required.
	Physician/surgeon fees	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% 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	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% 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 0% Coinsurance	Subject to deductible, then 40% Coinsurance	Prior Authorization required.
If you are pregnant	Office Visits	No Charge	Subject to deductible, then 40% 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	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	
	Childbirth/delivery facility services	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	None
	Rehabilitation services	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	120 visit(s) per year. Includes physical therapy, speech therapy and occupational therapy.
	Habilitation services	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	120 visit(s) per year
	Skilled nursing care	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	100 days per year
	Durable medical equipment	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% Coinsurance	1 item(s) per 3 years
	Hospice Services	Subject to deductible, then 0% Coinsurance	Subject to deductible, then 40% 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 40% Coinsurance	1 exam(s) per year nnnn 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: www.hometownhealth.com or call 800-336-0123

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, kwijigo holne' [800-336-0123].]

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](#) \$5,000
- [Specialist coinsurance](#) Not Applicable
- Hospital (facility) [coinsurance](#) Not Applicable
- Other [coinsurance](#) Not Applicable

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	\$5,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$5,000

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist coinsurance](#) Not Applicable
- Hospital (facility) [coinsurance](#) Not Applicable
- Other [coinsurance](#) Not Applicable

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	\$1,100
Copayments	\$0
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](#) \$5,000
- [Specialist coinsurance](#) Not Applicable
- Hospital (facility) [coinsurance](#) Not Applicable
- Other [coinsurance](#) Not Applicable

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

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: