



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.MyRBABenefits.com or by calling 1-877-498-1382. 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.MyRBABenefits.com or call 1-877-498-1382 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$500 person / \$1,000 family In-network \$15,000 person / \$30,000 family Out-of-network	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 deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$5,000 person / \$10,000 family In-network \$19,650 person / \$39,300 family Out-of-network	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, premiums , balance billing charges, and health care this plan doesn't cover. Also, certain specialty pharmacy drugs are considered nonessential health benefits and fall outside the out-of-pocket limits.	Even though you pay these expenses, they don't count toward the out-of-pocket limit . For certain specialty drugs, the cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.
Will you pay less if you use a network provider ?	Yes. See www.MyRBABenefits.com or call 1-877-498-1382 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 .
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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	\$75 Copay per visit; Deductible Waived	50% Coinsurance	None
	Specialist visit	\$100 Copay per visit; Deductible Waived	50% Coinsurance	None
	Preventive care/screening/immunization	No charge; Deductible Waived	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$200 Copay per visit	50% Coinsurance	None

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)	
	Imaging (CT/PET scans, MRIs)	\$500 Copay per visit	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.express-scripts.com .	Generic drugs (Tier 1)	Retail: \$30 copay Mail: \$75 copay	N/A	Dispense as Written (DAW) Policy: If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Brand copay plus the difference in cost between the Generic and Brand name drug. The Generic Policy does not apply if your doctor requires a brand name medication.
	Preferred brand drugs (Tier 2)	Retail: \$100 copay Mail: \$250 copay	N/A	
	Non-preferred brand drugs (Tier 3)	Retail: \$150 copay Mail: \$375 copay	N/A	
	Specialty drugs (Tier 4)	\$500 Copayment	N/A	Specialty medications are limited to 31-day supply and must be ordered from Express Scripts pharmacy Accredo at 1-800-803-2523. Specialty medications require prior authorization and quantity limits, or step therapy may apply. Please see "Important Questions" regarding the plan's out-of-pocket limit.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	\$1,000 Copay per visit	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits

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)	
surgery	Physician/surgeon fees	\$500 Copay per visit	50% Coinsurance	could be reduced by 50% of the total cost of the service.
If you need immediate medical attention	Emergency room care	\$500 Copay per visit True ER; 50% Coinsurance Non-true ER	\$500 Copay per visit True ER; 50% Coinsurance Non-true ER	In-network deductible applies to Out-of-network benefits True ER; Copay may be waived if admitted
	Emergency medical transportation	No charge True emergency ambulance; 50% Coinsurance Non-true emergency ambulance	No charge True emergency ambulance; 50% Coinsurance Non-true emergency ambulance	\$25,000 Maximum benefit per occurrence air ambulance
	Urgent care	\$100 Copay per visit; Deductible Waived	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$2,500 Copay per admission	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service for Out-of-network.
	Physician/surgeon fee	No charge physician; \$500 Copay per visit surgeon	50% Coinsurance	

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 have mental health, behavioral health, or substance abuse needs	Outpatient services	\$75 Copay per visit; Deductible Waived office visits; \$500 Copay per visit other outpatient services	50% Coinsurance	Preauthorization is required for Partial hospitalization & Intensive outpatient. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Inpatient services	\$2,500 Copay per admission facility; No charge physician	50% Coinsurance	
If you are pregnant	Office visits	No charge; Deductible Waived	50% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge physician; \$500 Copay per visit surgeon	50% Coinsurance	
	Childbirth/delivery facility services	\$2,500 Copay per admission	50% Coinsurance	

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 help recovering or have other special health needs	Home health care	\$75 Copay per visit	50% Coinsurance	60 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Rehabilitation services	\$100 Copay per visit; Deductible Waived office therapy; \$150 Copay per visit hospital therapy	50% Coinsurance	60 Maximum visits per calendar year
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	\$200 Copay per admission	50% Coinsurance	60 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service for Out-of-network.
	Durable medical equipment	\$100 Copay per rental or purchase	50% Coinsurance	Preauthorization is required for DME in excess of \$1,500 for purchases & all rentals. If you don't get preauthorization, benefits could be reduced by 50% per occurrence.
	Hospice service	No charge	50% Coinsurance	360 Maximum days per lifetime; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
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](#) Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Bariatric surgery (In-network only)
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

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 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](#). Additionally, a consumer assistance program may help you file your [appeal](#). A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

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 Standard? 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](#).

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 in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$500
■ Specialist copayment	\$100
■ Hospital (facility) copayment	\$2,500
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*pre-natal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$4,500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,060

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	\$100
■ Hospital (facility) copayment	\$2,500
■ Other coinsurance	0%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$500
Copayments	\$2,200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$800
The total Joe would pay is	\$3,500

Mia's Simple Fracture

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$100
■ Hospital (facility) copayment	\$2,500
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$500
Copayments	\$1,400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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: www.MyRBABenefits.com or call 1-877-498-1382.

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.