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, 1-866-815-6001. 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.cciio.cms.gov.

Important Questions	In- Network		Out- of-Network	Why This Matters:
Plan Name	Unity Guard 7500			The Plan Name identifies the specific plan type and its associated benefits, coverage, and cost-sharing arrangements.
What is the overall deductible?	Individual: $7,500	Family: $15,000	Not Covered	This is the amount you must pay out-of-pocket for covered services before your benefit plan starts to contribute to the costs.
What is the out-of-pocket limit for this plan?	Individual: $9,200	Family: $18,400	Not Covered	An out-of-pocket maximum in health benefit is the maximum amount you'll pay for covered healthcare services in a plan year.
Additional Plan Information:				
Plan Type	Limited Medical EPO – Exclusive Provider Organization			A health benefit plan type defines the structure of how your health benefit works, including how you access care, what costs are covered, and how much you pay out-of-pocket.
Network	First Health			The network refers to a group of healthcare providers, such as doctors, hospitals, and pharmacies, that have contracted with a plan benefit company to provide services at discounted rates to the company's members.
Pharmacy Benefit Manager	Ventegra- Acute Formulary			Pharmacy Benefit Manager (PBM) is a company that manages prescription drug benefits for health insurers, employers, and other payers.
Telemedicine Platform / Services	MyLiveDoc			A telemedicine platform is a technology system that facilitates remote medical consultations, typically through video conferencing, while ensuring patient privacy, security, and data compliance.
Are there services covered before you meet your deductible?	Yes. Preventive care services, office visits, & urgent care are covered before you meet your deductible.			This plan covers some items and services even if you haven't met your deductible. 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 do not have to meet your deductible for specific services.
What is not included in the out-of-pocket limit?	Premiums, pre-certification penalties, balance billed charges, & health care this plan does not cover.			Even though you pay these out-of-pocket expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes			If you use an in-network provider, you will pay less. If you use an out-of-network provider, you will pay more.
Do you need a referral to see a specialist?	No			A referral to a specialist is a recommendation or direction from a primary care physician (PCP) or another healthcare provider to see a specialist who has expertise in a specific area of medicine.

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 – including provider telemedicine visits	$40 Copayment	Not Covered	Visit Limit 5
	Specialist Visit – including provider telemedicine visits	$50 Copayment	Not Covered	Visit Limit 5
	Preventive Care/Screening/ immunization	No Charge	Not Covered	
Telemedicine – Through Plan Preferred Telemedicine Platform	➢ Virtual Primary Care	$0 Copayment	Not Covered	12 Visit Limit
	➢ Virtual Mental Health	$0 Copayment	Not Covered	
	➢ Virtual Urgent Care	$0 Copayment	Not Covered	
If you have a test	Diagnostic Test (x-ray, blood work)	$80 Copayment	Not Covered	Limit to 1 per benefit period
	Imaging (CT/PET scans, MRIs)	$275 Copayment	Not Covered	Limit to 1 per benefit period
If you need drugs to treat your illness or condition	Generic drugs	$12 Copayment	Not Covered	Ventegra is the Pharmacy Benefit Manager – Acute Formulary Only - 30 Day Supply Retail Mail Order - Plan Contributes $3.00 on Each 30-Day Fill and $6.00 for 90-Day Fills
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty Drugs	Not Covered	Not Covered	Access Patient Assistance through ScriptAide - Availability based on Foundational Program Rules, including income requirements
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$700 Copayment after Deductible	Not Covered	Limit 1 per family per benefit period
	Physician/surgeon fees	Deductible	Not Covered	
If you need immediate medical attention	Emergency Room Care	$300 Copayment after Deductible	In Network Level of Benefits – (Not Covered if the visit was not an emergency)	Limit to 1 per family per benefit period
	Emergency Medical Transportation	$1,250 Max payment after Deductible	In Network Level of Benefits - (Not Covered if the transport was not an emergency)	Limit to 1 per family per benefit period

	Urgent Care	$60 Copayment	Not Covered	Limit to 2 per benefit period
If you have a hospital stay	Facility fee (e.g., hospital room)	$2,250 Copayment after Deductible	Not Covered	Limit to 1 per family per benefit period x3 days
	Physician/surgeon fees	Deductible	Not Covered	
Mental Health Services Behavioral Health Services Substance Abuse Services	Outpatient services	$50 Copayment after Deductible	Not Covered	Limit 3 Visits
	Inpatient services	$250 Copayment after Deductible	Not Covered	Limit 3 Days
If you are pregnant	Office visits	Not Covered	Not Covered	
	Childbirth/delivery professional services	Not Covered	Not Covered	
	Childbirth/delivery facility services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Rehabilitation services	$50 Copayment after Deductible	Not Covered	Combined 3 Visit Limit
	Habilitation services	$50 Copayment after Deductible	Not Covered	
	Skilled nursing care	$50 Copayment after Deductible	Not Covered	Combined 3 Visit Limit
	Durable medical equipment	$100 Copayment after Deductible	Not Covered	1 per benefit period
	Hospice services	$50 Copayment after Deductible	Not Covered	Combined 3 Visit Limit
	Home health care	$50 Copayment after Deductible	Not Covered	Combined 3 Visit Limit
	Chemo/Radiation (Outpatient)	$150 Copayment after Deductible	Not Covered	5 Visit Limit
	Prosthetics & Orthotics	$500 Max per Benefit Period	Not Covered	1 per benefit period
Allergy Services	Allergy Testing	$50 Copayment	Not Covered	Limit to 2 per benefit period
	Allergy Shots	$25 Copayment	Not Covered	Limit to 5 per benefit period
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	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.)		
• Infertility Treatments	• Weight Loss Programs & Surgery	• Experimental Procedures
• Private Duty Nursing	• Cosmetic Surgery	• Maternity

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

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 benefit coverage through the Health Benefit 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 benefit 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 [866-815-6001] [Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [866-815-6001] [Chinese (中文): 如果需要中文的帮助，请拨打这个号码[866-815-6001] [Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [866-815-6001]

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.

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $
- **Specialist** *[cost sharing]* $
- **Hospital (facility)** *[cost sharing]* %
- **Other** *[cost sharing]* %

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	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$12,700
The total Peg would pay is	**$12,700**

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

- **The plan's overall deductible** $1500
- **Specialist** *[cost sharing]* $
- **Hospital (facility)** *[cost sharing]* %
- **Other** *[cost sharing]* %

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	$1500
Copayments	$50
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$1550**

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

- **The plan's overall deductible** $1500
- **Specialist** *[cost sharing]* $
- **Hospital (facility)** *[cost sharing]* %
- **Other** *[cost sharing]* %

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	$1500
Copayments	$250
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$1750**