**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 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** | Livelihood 4300 EPO | | | The Plan Name identifies the specific plan type and its associated benefits, coverage, and cost-sharing arrangements. |
| **What is the overall deductible?** | Individual: $ 4,300 | Family: $ 8,600 | No Out of Network Coverage | This is the amount you must pay out-of-pocket for covered services before your insurance plan starts to contribute to the costs. |
| **What is the out-of-pocket limit for this plan?** | Individual: $ 10,000 | Family: $ 20,000 | No Out of Network Coverage | An out-of-pocket maximum in health insurance is the maximum amount you'll pay for covered healthcare services in a plan year. |
| **Coinsurance** | 20% / 80% | | No Out of Network Coverage | This is the percentage of the cost for a covered service that you, the insured, pay after you have met your deductible. The plan pays the difference. Example Only: 20% is member responsibility, 80% is plan responsibility. |
| **Plan Type** | Exclusive Provider Organization (EPO) | | | A health insurance plan type defines the structure of how your health insurance works, including how you access care, what costs are covered, and how much you pay out-of-pocket. |
| **Additional Plan Information** | | | | |
| **Network** | Aetna | | | The network refers to a group of healthcare providers, such as doctors, hospitals, and pharmacies, that have contracted with an insurance company to provide services at discounted rates to the company's members. |
| **Pharmacy Benefit Manager** | Kroger | | | 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: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 Copayment | Not Covered | |
| | Specialist visit | $40 Copayment | Not Covered | |
| | Telemedicine Visits | Through Telemedicine Platform -No Charge<br>If not through telemedicine platform- $25 Copayment | Not Covered | |
| | Preventive care/screening/ immunization | No Charge | Not Covered | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab: $25 Copayment per visit<br>X-Ray: $100 Copayment per visit | Not Covered | |
| | Imaging (CT/PET scans, MRIs) | Deductible then 20% Coinsurance | Not Covered | |
| **If you need drugs to treat your illness or condition** | Generic drugs | $5 Copayment per prescription – Deductible does not apply | Not Covered | 30 Day Retail Supply- Kroger<br>90 Day Mail Order Supply- Postal Prescription Services |
| | Preferred brand drugs | When no Generic medication available, Brand medication available ScriptAide | Not Covered | |
| | Non-preferred brand drugs | Not Covered | Not Covered | |
| | Specialty drugs | Contact ScriptAide for potential assistance | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Deductible then 20% Coinsurance | Not Covered | |
| | Physician/surgeon fees | Deductible then 20% Coinsurance | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | Deductible then 20% Coinsurance | In Network Level of Benefits | Must be Emergent to Qualify for Out of Network Benefits |
| | Emergency medical transportation | Deductible then 20% Coinsurance | In Network Level of Benefits | Must be Emergent to Qualify for Out of Network Benefits |

| | | | | | |
|---|---|---|---|---|---|
| | Urgent care | $60 Copayment | Not Covered | | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Deductible then 20% Coinsurance | Not Covered | | |
| | Physician/surgeon fees | Deductible then 20% Coinsurance | Not Covered | | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Deductible then 20% Coinsurance | Not Covered | | |
| | Inpatient services | Deductible then 20% Coinsurance | Not Covered | | |
| | Telemedicine Visits | Through Telemedicine Platform -No Charge<br>If not through telemedicine platform- $25 Copayment | Not Covered | | |
| **If you are pregnant** | Office visits | $25 Copayment | Not Covered | | |
| | Childbirth/delivery professional services | Deductible then 20% Coinsurance | Not Covered | | |
| | Childbirth/delivery facility services | Deductible then 20% Coinsurance | Not Covered | | |
| **If you need help recovering or have other special health needs** | Home health care | Deductible then 20% Coinsurance | Not Covered | Rehabilitative services are limited to 35 visits per calendar year combined with Cardiac & Pulmonary Rehabilitation services.<br>Habilitative services are limited to 35 visits per calendar year combined with Rehabilitative, Cardiac & Pulmonary Rehabilitation services.<br>Chiropractic services are limited to 35 visits per calendar year combined with all Therapy and Rehabilitation Services.<br>Home Health Aide and Respiratory Care (Benefits are limited to 60 visits each calendar year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% to a maximum of $500.)<br>Skilled Nursing Care (Benefits are limited to 60 visits each calendar year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% to a maximum of $500.) | |
| | Rehabilitation services | Deductible then 20% Coinsurance | Not Covered | | |
| | Habilitation services | Deductible then 20% Coinsurance | Not Covered | | |
| | Skilled nursing care | Deductible then 20% Coinsurance | Not Covered | | |
| | Durable medical equipment | Deductible then 20% Coinsurance | Not Covered | | |
| | Hospice services | Deductible then 20% Coinsurance | Not Covered | | |
| **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 | • Private Duty Nursing | • Experimental or Investigational Treatments |
| • Weight Loss Programs / Surgery | • Cosmetic Surgery | • Personal Comfort Items |
| **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 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 [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 Plans over all Deductible: | $4,300 |
| Specialist (Cost Sharing): | $40 |
| Hospital (Facility) (Cost Sharing): | 20% |
| Other (Cost Sharing): | 20% |
| This example event includes services like:<br>- Specialist Office Visits (prenatal care)<br>- Childbirth/Delivery Professional Services<br>- Childbirth/Delivery Facility Services<br>- Diagnostic Tests (Ultrasounds & blood work)<br>- Specialist Visits (Anesthesia) | |
| **Total Example Cost:** | **$12,700** |
| Deductibles: | $4,300 |
| Copayments: | $40 |
| Coinsurance: | $1,680 |
| What isn't Covered? | |
| Limits or Exclusions: | $ |
| **The total Peg would pay is:** | **$6,020** |

| **Managing Joe's Type 2 Diabetes** (a year of routine in-network care of a well-controlled condition) | |
|---|---|
| The Plans over all Deductible: | $4,300 |
| Specialist (Cost Sharing): | $40 |
| Hospital (Facility) (Cost Sharing): | 20% |
| Other (Cost Sharing): | 20% |
| This example event includes services like:<br>- Primary Care Physician Office Visits (Including disease education)<br>- Diagnostic Test (blood work)<br>- Prescription Drugs<br>- Durable Medical Equipment (glucose meter) | |
| **Total Example Cost:** | **$5,600** |
| Deductibles: | $4,300 |
| Copayments: | $40 |
| Coinsurance: | $260 |
| What isn't Covered? | |
| Limits or Exclusions: | $ |
| **The total Joe would pay is:** | **$4,600** |

| **Mia's Simple Fracture** (in-network emergency room visit and follow up care) | |
|---|---|
| The Plans over all Deductible: | $4,300 |
| Specialist (Cost Sharing): | $40 |
| Hospital (Facility) (Cost Sharing): | 20% |
| Other (Cost Sharing): | 20% |
| This example event includes services like:<br>- Emergency Room Care (Including Medical Supplies)<br>- Diagnostic Tests (x-ray)<br>- Durable medical Equipment (crutches)<br>- Rehabilitation Services (Physical Therapy) | |
| **Total Example Cost:** | **$2,800** |
| Deductibles: | $2,760 |
| Copayments: | $40 |
| Coinsurance: | $0 |
| What isn't Covered? | |
| Limits or Exclusions: | $ |
| **The total Mia would pay is:** | **$2,800** |