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 3350 EPO			The Plan Name identifies the specific plan type and its associated benefits, coverage, and cost-sharing arrangements.
What is the overall deductible?	Individual: $ 3,350	Family: $ 6,700	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 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 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 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 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. Habilitative services are limited to 35 visits per calendar year combined with Rehabilitative, Cardiac & Pulmonary Rehabilitation services. Chiropractic services are limited to 35 visits per calendar year combined with all Therapy and Rehabilitation Services. 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.) 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:	$3350
Specialist (Cost Sharing):	$40
Hospital (Facility) (Cost Sharing):	20%
Other (Cost Sharing):	20%
This example event includes services like: • Specialist Office Visits (prenatal care) • Childbirth/Delivery Professional Services • Childbirth/Delivery Facility Services • Diagnostic Tests (Ultrasounds & blood work) Specialist Visits (Anesthesia)	
Total Example Cost: $12,700	
Deductibles:	$3350
Copayments:	$40
Coinsurance:	$2540
What isn't Covered?	
Limits or Exclusions:	$
The total Peg would pay is:	$5930

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The Plans over all Deductible:	$3350
Specialist (Cost Sharing):	$40
Hospital (Facility) (Cost Sharing):	20%
Other (Cost Sharing):	20%
This example event includes services like: • Primary Care Physician Office Visits (Including disease education) • Diagnostic Test (blood work) • Prescription Drugs Durable Medical Equipment (glucose meter)	
Total Example Cost: $5,600	
Deductibles:	$3350
Copayments:	$40
Coinsurance:	$1120
What isn't Covered?	
Limits or Exclusions:	$
The total Joe would pay is:	$4510

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The Plans over all Deductible:	$3350
Specialist (Cost Sharing):	$40
Hospital (Facility) (Cost Sharing):	20%
Other (Cost Sharing):	20%
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	
Deductibles:	$2760
Copayments:	$40
Coinsurance:	$0
What isn't Covered?	
Limits or Exclusions:	$
The total Mia would pay is:	$2800