**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 ironroadhealthcare.com or call 800-547-0421. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$** 0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | **Not Applicable** | You don't have to meet deductibles for covered services |
| **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?** | **$9,100, However, only coverage for in-network Essential Health Benefits counts towards meeting the out-of-pocket limit** | The **out-of-pocket limit** is the most you could pay in a year for in-network services for covered Essential Health Benefits (EHB) services. (EHB are those benefits defined as such by the Affordable Care Act). Once the out-of-pocket limit is met, covered in-network EHBs are paid 100%. |
| **What is not included in the out-of-pocket limit?** | **Premiums, balance-billed** charges, **preventive services,** healthcare this **plan** doesn't cover, penalties for failure to obtain required **preauthorization**, out-of-network services, Non-Essential Benefits. | Even though you pay these expenses out-of-pocket, they don't count toward the Plan **out-of-pocket limit**. Benefit are not EHBs include such benefits as those for Bariatric Surgery, Hearing aids, Lasik Surgery, and Male Sterilization. Whether or not you have reached the out-of-pocket limit for EHBs, coverage for Non-EHBs remains the same and may include copayments and coinsurance. |
| **Will you pay less if you use a network provider?** | Yes. Visit www.ironroadhealthcare.com or call 800-547-0421 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plans 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. |



*For more information about limitations and exceptions, see the plan or policy document at www.ironroadhealthcare.com

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 | $30 visit | $30 visit 60% coinsurance | ----------None---------- |
| | Specialist visit | $45 visit | $45 visit 60% coinsurance | ----------None---------- |
| | Preventive care/screening/ immunization | No charge | 60% 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) | No charge | 60% coinsurance | ----------None---------- |
| | Sleep Study | No charge | 60% coinsurance | Pre-Certification required 1-833-878-2727. |
| | Imaging (CT/PET scans, MRIs) | $150 visit | $150 visit 60% coinsurance | Pre-Certification required through Telligen 877-654-1375 |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.ironroadhealthcare.com | Generic drugs | Retail preferred $15 or $20 for 30-day supply. Mail order preferred $3 or $10 for 30-day supply | Retail preferred $15 or $20 for 30-day supply. Mail order preferred $3 or $10 for 30-day supply | Covers up to a 30-day supply (retail); 31-90-day supply (mail order pharmacy) |
| | Preferred brand drugs | $40 visit retail<br>$20 visit mail order | $40 visit retail<br>$20 visit mail order | Covers up to a 30-day supply (retail); 31-90-day supply (mail order pharmacy) |
| | Non-preferred brand drugs | $100 visit retail<br>$75 visit mail order | $100 visit retail<br>$75 visit mail order | Covers up to a 30-day supply (retail) 31-90-day supply (mail order) |
| | Specialty drugs | Variable | Variable | Must use OptumRx Specialty Pharmacy 800-850-9122 to be covered. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $150 visit | $150 visit 60% coinsurance | ----------None---------- |
| | Physician/surgeon fees | No charge | 60% Coinsurance | ----------None---------- |
| **If you need immediate medical attention** | Emergency room care | $175 visit | $175 visit, first 24hours pays 100% allowed amount, 60% coinsurance | If admitted inpatient, ER copay is waived. Pre-cert required 866-776-4793. Services outside the United States is not covered. |

| 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) | |
| | Emergency medical transportation | No charge | No charge | Services outside the United States is not covered. |
| | Urgent care | $30-visit | $30 visit | Services outside the United States is not covered. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $250 visit | $250 visit & 60% coinsurance | Pre-cert required if not a 60% reduction applies 866-776-4793 |
| | Physician/surgeon fees | No charge | 60% coinsurance | ----------None---------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 visit $45 for specialty psychiatrist office visit | $30/$45 visit 60% coinsurance | IOP (intensive out-patient therapy) Pre-certification required if not a 60% reduction applies 866-776-4793 |
| | Inpatient services | $250 visit | $250 visit & 60% coinsurance | Pre-certification required if not a 60% reduction applies 866-776-4793 |
| **If you are pregnant** | Office visits | No charge | 60% coinsurance | ----------None---------- |
| | Childbirth/delivery professional services | No charge | 60% coinsurance | ----------None---------- |
| | Childbirth/delivery facility services | $250 visit | $250 visit & 60% coinsurance | Pre-certification required, only if beyond days allowed by law 866-776-4793. |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 60% coinsurance | Pre-certification required 800-547-0421 a 60% reduction will apply |
| | Rehabilitation services | No charge for PTT & OT. A Chiropractic visit has a $30 copay | 60% coinsurance No charge for PTT & OT. A Chiropractic visit has a $30 copay | Combined annual maximum of 30 visits for Physical Therapy, Chiropractic and Occupational therapy. |
| | Habilitation services | No charge | 60% coinsurance | Limited |
| | Skilled nursing care | No charge | 60% coinsurance | Pre-certification required 800-547-0421 a 60% reduction will apply |
| | Durable medical equipment | No charge | 60% coinsurance | Limited |
| | Hospice services | No charge | 60% coinsurance | Pre-certification required 800-547-0421 a 60% reduction will apply |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | |
| | Children's glasses | Not covered | Not covered | |

| 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) | |
| | 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 treatment
- Cosmetic Surgery
- Private-duty nursing
- Long term care
- Dental Care
- Weight loss medication
- Services outside the U.S.
- Dependents are not covered
- Acupuncture

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

- Bariatric
- Chiropractic care
- Hearing aids
- Sterilization
- Physical therapy
- Occupational therapy

**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 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**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 1-800-318-2596.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-318-2596.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-318-2596.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-318-2596.

*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-

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *[cost sharing]* | $45 |
| Hospital (facility) *[cost sharing]* | $250 |
| Other *[cost sharing]* | 0% |

**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** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $295 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$295** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *[cost sharing]* | $45 |
| Hospital (facility) *[cost sharing]* | $250 |
| Other *[cost sharing]* | $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** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $295 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$295** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *[cost sharing]* | $45 |
| Hospital (Emergency facility) | $175 |
| Other *[cost sharing]* | $0 |

**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** | **$20,000** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $220 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$220** |

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