




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](http://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 <a href="#">deductible</a> ?	\$ 0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not Applicable	You don't have to meet <a href="#">deductibles</a> for covered services
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$9,100, However, only coverage for in-network Essential Health Benefits counts towards meeting the <a href="#">out-of-pocket limit</a></b>	The <b><a href="#">out-of-pocket limit</a></b> 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 <a href="#">out-of-pocket limit</a> is met, covered in-network EHBs are paid 100%.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<b><a href="#">Premiums</a>, <a href="#">balance-billed charges</a>, <a href="#">preventive services</a>, healthcare this <a href="#">plan</a> doesn't cover, penalties for failure to obtain required <a href="#">preauthorization</a>, out-of-network services, Non-Essential Benefits.</b>	Even though you pay these expenses <a href="#">out-of-pocket</a> , they don't count toward the Plan <b><a href="#">out-of-pocket limit</a></b> . 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 <a href="#">out-of-pocket limit</a> for EHBs, coverage for Non-EHBs remains the same and may include copayments and coinsurance.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Visit <a href="http://ironroadhealthcare.com">ironroadhealthcare.com</a> or call 800-547-0421 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plans <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (balance billing). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 visit	\$30 visit 60% coinsurance	-----None-----
	<a href="#">Specialist</a> visit	\$45 visit	\$45 visit 60% coinsurance	-----None-----
	<a href="#">Preventive care/screening/immunization</a>	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	60% coinsurance	-----None-----
	Sleep Study	100%	60%	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 <a href="#">prescription drug coverage</a> is available at <a href="#">ironroadhealthcare.com</a>	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 \$20 visit mail order	\$40 visit retail \$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 \$75 visit mail order	\$100 visit retail \$75 visit mail order	Covers up to a 30-day supply (retail) 31-90-day supply (mail order)
	<a href="#">Specialty drugs</a>	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	<a href="#">Emergency room care</a>	\$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)	
	<a href="#">Emergency medical transportation</a>	No charge	No charge	Services outside the United States is not covered.
	<a href="#">Urgent care</a>	\$30-visit	\$30 visit	Services outside the United States is not covered.
<b>If you have a hospital stay</b>	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-----
<b>If you need mental health, behavioral health, or substance abuse services</b>	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
<b>If you are pregnant</b>	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.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	60% coinsurance	Pre-certification required 800-547-0421 a 60% reduction will apply
	<a href="#">Rehabilitation services</a>	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.
	<a href="#">Habilitation services</a>	No charge	60% coinsurance	Limited
	<a href="#">Skilled nursing care</a>	No charge	60% coinsurance	Pre-certification required 800-547-0421 a 60% reduction will apply
	<a href="#">Durable medical equipment</a>	No charge	60% coinsurance	Limited
	<a href="#">Hospice services</a>	No charge	60% coinsurance	Pre-certification required 800-547-0421 a 60% reduction will apply
<b>If your child needs dental or eye care</b>	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 | • Long term care         | • Services outside the U.S.  |
| • Cosmetic Surgery      | • Dental Care            | • Dependents are not covered |
| • Private-duty nursing  | • Weight loss medication | • Acupuncture                |

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

- |                     |                 |                        |
|---------------------|-----------------|------------------------|
| • Bariatric         | • Hearing aids  | • Physical therapy     |
| • Chiropractic care | • Sterilization | • 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](http://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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

—————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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$45
■ Hospital (facility) [ <i>cost sharing</i> ]	\$250
■ Other [ <i>cost sharing</i> ]	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$295
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$295</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$45
■ Hospital (facility) [ <i>cost sharing</i> ]	\$250
■ Other [ <i>cost sharing</i> ]	\$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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$295
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$295</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$45
■ Hospital (Emergency facility)	\$175
■ Other [ <i>cost sharing</i> ]	\$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*)

<b>Total Example Cost</b>	<b>\$20,000</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$220
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$220</b>