



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, [insert contact information]. 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.healthcare.gov/sbc-glossary/ or call 1-xxx-xxx-xxxx to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$6,000 Individual / \$12,000 Family <u>Deductible</u> is embedded.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Open network <u>preventive care</u> and services covered at "No charge".	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$12,000 Individual / \$24,000 Family <u>Out-Of-Pocket Limit</u> is embedded.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, Pre-Certification penalties, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	No.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Open Network Provider (You will pay the least)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$60 <u>copay</u> (<u>Deductible</u> Waived)	
	<u>Specialist</u> visit	\$60 <u>copay</u> (<u>Deductible</u> Waived)	
	<u>Preventive care/screening/immunization</u>	0% <u>coinsurance</u> (<u>Deductible</u> waived)	Pre-Certification required. No coverage if not obtained.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	40% <u>coinsurance</u> after <u>deductible</u>	Pre-Certification required. No coverage if not obtained.
	<u>Basic Lab</u>	\$50 <u>copay</u> (<u>Deductible</u> Waived)	
	Imaging (CT/PET scans, MRIs)	40% <u>coinsurance</u> after <u>deductible</u>	Pre-Certification required. No coverage if not obtained.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.[insert].com	Generic drugs	Discount card only.	<u>Prescription drugs</u> . (Generic) \$15 copay (<u>Deductible</u>)
	Preferred brand drugs	Discount card only.	
	Non-preferred brand drugs	Discount card only.	Discount card only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u> after <u>deductible</u>	Pre-Certification required. No coverage if not obtained.
	Physician/surgeon fees	40% <u>coinsurance</u> after <u>deductible</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$500 <u>copay</u> (<u>Deductible</u> Waived), then 40% <u>coinsurance</u> after <u>deductible</u>	Pre-Certification required. No coverage if not obtained. if failure to pre-authorization in 30-days window claim denied.
	<u>Emergency medical transportation</u>	40% <u>coinsurance</u> after <u>deductible</u>	
	<u>Urgent care</u>	\$60 <u>copay</u> (<u>Deductible</u> Waived)	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <u>coinsurance</u> after <u>deductible</u>	Pre-Certification required. No coverage if not obtained.
	Physician/surgeon fees	40% <u>coinsurance</u> after <u>deductible</u>	
If you need mental	Outpatient services	40% <u>coinsurance</u> after <u>deductible</u>	Pre-Certification required. No coverage if not obtained

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

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
		Open Network Provider (You will pay the least)	
health, behavioral health, or substance abuse services	Inpatient services	40% coinsurance after deductible	Pre-Certification required. No coverage if not obtained. 5/days per calendar year.
If you are pregnant	Office visits	40% coinsurance after deductible	
	Childbirth/delivery professional services	40% coinsurance after deductible	
	Childbirth/delivery facility services	40% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	Pre-Certification required. No coverage if not obtained.
	Rehabilitation services	0% coinsurance after deductible	Pre-Certification required. No coverage if not obtained.
	Habilitation services	0% coinsurance after deductible	Physical, speech, occupational cardiac rehabilitation limited to 15 visits per Calendar Year, combined.
	Skilled nursing care	0% coinsurance after deductible	Pre-Certification required. No coverage if not obtained. 15 days/ Calendar Year.
	Durable medical equipment	0% coinsurance after deductible	Pre-Certification required. No coverage if not obtained.
	Hospice services	0% coinsurance after deductible	Pre-Certification required. No coverage if not obtained. 15 visits/days per lifetime.
If your child needs dental or eye care	Children's eye exam	No Charge	Coverage limited to one exam per Calendar Year
	Children's glasses	Not Covered	None
	Children's dental check-up	Not Covered	None

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 .)		
- Acupuncture - Bariatric surgery - Cosmetic surgery - Chemotherapy Services - Dental care (Adult) - Hearing aids & Services	- Infertility treatment - Long-term care (custodial care) - Non-emergency care when traveling outside the U.S. - Prescription Drugs (Preferred Brand, Non-Preferred Brand/Specialty)	- Podiatry Services - Private duty nursing - Routine eye care (Adult) - Routine foot care - Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
- Chiropractic care (15 visits per Plan Year) - Telemedicine \$0 (Deductible waived)		

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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: **Marpai at Attn: Appeal's Coordinator, PO Box 211291 Eagan, MN 55121 or 1-855-699-5433.**

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 1-855-699-5433.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-699-5433.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-699-5433.

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-699-5433.

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.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$5,000
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$2,800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$7,860

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$5,000
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$160
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$5,180

Mia's Simple Fracture

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

■ The plan's overall deductible	\$5,000
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.