



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, call 1-866-360-7926. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You may view the Glossary at healthcare.gov/sbc-glossary or call 1-866-360-7926 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In-network--Single Plan: \$500 employee Two Person Plan*: \$500 person/\$1,000 Two Person Family Plan**: \$500 person/\$1,500 family Out-of-network--Single Plan: \$1,000 employee Two Person Plan*: \$1,000 person/\$2,000 Two Person Family Plan**: \$1,000 person/\$3,000 family *Employee + One. **Employee & family	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. In-network <u>preventive services</u> and physician office visits are some of the services covered before you meet your <u>deductible</u> .	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 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>?	In-network--Single Plan: \$2,200 employee Two Person Plan*: \$2,200 person/\$4,400 Two Person Family Plan**: \$2,200 person/\$6,600 family Out-of-network--Unlimited *Employee + One. **Employee & family	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> , for In-network, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> is met, and, for Out-of-network, this <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u>?	<u>Preauthorization</u> penalties, <u>premiums</u> , <u>prescription drug copays</u> , chiropractic care, <u>balance-billing</u> charges 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>?	Yes. See CityofSavannahHealthPlan.com or call 1-866-360-7926 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You pay less if you use a <u>provider</u> in the <u>plan's network</u> . You 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 <u>provider's</u> 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 may see <u>specialist</u> you choose without a <u>referral</u> . However, <u>referrals</u> for Specialty Care are required to receive highest level of benefits under the <u>plan</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
		In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit; <u>deductible</u> waived	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if services are <u>preventive</u> . Then check what your <u>plan</u> will pay. <u>Preauthorization</u> required for Routine Colorectal Cancer Screening.
	<u>Specialist</u> visit--- With <u>Referral</u> Without <u>Referral</u>	\$25 <u>copay</u> /visit; <u>deductible</u> waived \$50 <u>copay</u> /visit; <u>deductible</u> waived	50% <u>coinsurance</u>	
	Preventive care/screening/immunization	No charge; <u>deductible</u> waived	Not covered	
If you have a test	<u>Diagnostic test</u> (x-rays, blood work)	No charge; <u>deductible</u> waived	50% <u>coinsurance</u>	<u>Preauthorization</u> required for MRIs, MRAs, PET, & PET/CT Scans.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition. Information about <u>prescription drug coverage</u> is available at CityofSavannahHealthPlan.com	Generic drugs— Retail (30 days) Retail (90 days) or Mail Order (90 days)	\$5 <u>copay</u> /script \$10 <u>copay</u> /script	Not covered	<u>Deductible</u> waived. <u>Prescription drug out-of-pocket limits</u> are \$3,450 per person, \$6,900 per Two Person and \$6,900 per family Certain <u>prescription drugs</u> are subject to Step Therapy. You may be required to use different <u>prescription drug</u> or pharmaceutical product(s) first.
	Preferred brand drugs— Retail (30 days) Retail (90 days) or Mail Order (90 days)	\$25 <u>copay</u> /script \$50 <u>copay</u> /script	Not covered	
	Non-preferred brand drugs— Retail (30 days) Retail (90 days) or Mail Order (90 days)	\$50 <u>copay</u> /script \$125 <u>copay</u> /script	Not covered	
	Specialty drugs--- Retail (30-days only)	\$75 <u>copay</u> /script	Not covered	
	Substitution of generic equivalent drug is required. If you request brand name drug be filled, you pay difference between brand & generic drug when generic drug is available. Difference in cost does not apply toward <u>prescription drug out-of-pocket limits</u> . Covered Persons with diabetes can earn reduced copays for diabetic medications & testing supplies by complying with Quantum Health Chronic Condition Management guidelines; see Complex Case Management/Alternate Treatment Coverage for additional information.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgical center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	In- <u>network deductible</u> ; then \$200 <u>copay</u> /visit; then 20% <u>coinsurance</u>		<u>Copay</u> waived if admitted
	<u>Emergency medical transportation</u>	In- <u>network deductible</u> ; then 20% <u>coinsurance</u>		None
	<u>Urgent care</u>	\$15 <u>copay</u> /visit; <u>deductible</u> waived	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	\$500 <u>copay</u> /admission then 50% <u>coinsurance</u>	<u>Preauthorization</u> required or you pay \$500 more
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</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
		In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	
If you need mental health, behavioral health or substance abuse services	Outpatient services— Office visit	\$15 <u>copay</u> /visit; <u>deductible</u> waived	50% <u>coinsurance</u>	<u>Preauthorization</u> required for Inpatient services or you pay \$500 more
	Intensive outpatient treatment	20% <u>coinsurance</u>		
	Inpatient services	20% <u>coinsurance</u>	\$500 <u>copay</u> /admission then 50% <u>coinsurance</u>	
If you are pregnant	Office visits	No charge; <u>deductible</u> waived	50% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Requires <u>preauthorization</u> for stays over 48 hrs (normal delivery)/96 hrs (caesarean) or you pay \$500 more
	Childbirth/delivery professional services	\$200 <u>copay</u> ; <u>deductible</u> waived	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	\$500 <u>copay</u> /admission then 50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$20 <u>copay</u> /visit; <u>deductible</u> waived	50% <u>coinsurance</u>	<u>Preauthorization</u> required. 120 visits/yr
	<u>Rehabilitation services</u> — Inpatient	20% <u>coinsurance</u>	In-network <u>deductible</u> ; then \$500 <u>copay</u> /admission; then 20% <u>coinsurance</u>	90 days/yr. <u>Preauthorization</u> required for Inpatient or you pay \$500 more.
	Outpatient	20% <u>coinsurance</u>	50% <u>coinsurance</u>	30 visits/yr each for Physical, Occupational & Speech therapies.
	<u>Habilitation services</u> — Early Intervention Developmental Delay	20% <u>coinsurance</u> 20% <u>coinsurance</u>	50% <u>coinsurance</u> 50% <u>coinsurance</u>	to age 3 <u>Preauthorization</u> & visit limits based on services provided
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	In-network <u>deductible</u> ; then \$500 <u>copay</u> /admission; then 20% <u>coinsurance</u>	90 days/yr. <u>Preauthorization</u> required or you pay \$500 more
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for all rentals & equipment over \$1,500
	<u>Hospice services</u>	No charge; <u>deductible</u> waived	50% <u>coinsurance</u>	<u>Preauthorization</u> required. 180 days/lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	n/a
	Children's glasses	Not covered	Not covered	n/a
	Children's dental check-up	Not covered	Not covered	n/a

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 | • Cosmetic surgery | • Dental care (routine child & adult) |
| • Infertility Treatment | • Long term care | • Non-emergency care when traveling outside U.S. |
| • Routine eye care (adult & child) | • Routine foot care | |

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

- | | | |
|------------------------|------------------------------------|------------------------------|
| • Bariatric Surgery | • Chiropractic care (25 visits/yr) | • Hearing aids (1 set/5 yrs) |
| • Private Duty Nursing | • Weight loss programs | |

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 U.S. Department of Labor, 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact the plan at 1-866-360-7926. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 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 1-866-360-7926; Portuguese (Português): De assistência em Português, ligue 1-866-360-7926

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-360-7926

————— *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-only coverage.

Peg is Having a Baby

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

■ The plan's overall <u>deductible</u>	\$500
■ Specialist <u>copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>no charge</u>	

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
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$10
Coinsurance	\$1,600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,170

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$500
■ Specialist <u>copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$300
Coinsurance	\$60
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$880

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$500
■ Specialist <u>copayment</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$300
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100