




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, Contact Health at 877-872-4232. 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.dol.gov/ebsa/healthreform or call 1-877-872-4232 to request a copy.

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	
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 ?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider ?	Not Applicable	Any procedure not covered by Alternate Coverage will not be reimbursed under this plan.
Do you need a referral to see a specialist ?	Indirectly only	This plan does not reimburse for expenses not paid by the Alternate Coverage, and the Alternate Coverage may use a network of providers.

 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	\$0	\$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to the ACA limits per year as follows: 100% for all North Oaks billed services and 75% for all Non-North Oaks billed services. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Specialist visit	\$0	\$0	
	Preventive care/screening/immunization	\$0	\$0	
If you have a test	Diagnostic test (x-ray, blood work)	\$0	\$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to the ACA limits per year as follows: 100% for all North Oaks billed services and 75% for all Non-North Oaks billed services. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Imaging (CT/PET scans, MRIs)	\$0	\$0	
If you need drugs to treat your illness or condition	Generic drugs	\$0	\$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to the ACA limits per year as follows: 100% for all North Oaks billed services and 75% for all Non-North Oaks billed services. Any drug not covered by the Alternate Coverage will not be reimbursed under this plan.
	Preferred brand drugs	\$0	\$0	
	Non-preferred brand drugs	\$0	\$0	
	Specialty drugs	\$0	\$0	

* For more information about limitations and exceptions, see the [plan](#) or policy document.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0	\$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to the ACA limits per year as follows: 100% for all North Oaks billed services and 75% for all Non-North Oaks billed services. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Physician/surgeon fees	\$0	\$0	
If you need immediate medical attention	Emergency room care	\$0	\$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to the ACA limits per year as follows: 100% for all North Oaks billed services and 75% for all Non-North Oaks billed services. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Emergency medical transportation	\$0	\$0	
	Urgent care	\$0	\$0	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0	\$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to the ACA limits per year as follows: 100% for all North Oaks billed services and 75% for all Non-North Oaks billed services. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Physician/surgeon fees	\$0	\$0	

* For more information about limitations and exceptions, see the [plan](#) or policy document.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$0	\$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to the ACA limits per year as follows: 100% for all North Oaks billed services and 75% for all Non-North Oaks billed services. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Inpatient services	\$0	\$0	
If you are pregnant	Office visits	\$0	\$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to the ACA limits per year as follows: 100% for all North Oaks billed services and 75% for all Non-North Oaks billed services. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Childbirth/delivery professional services	\$0	\$0	
	Childbirth/delivery facility services	\$0	\$0	
If you need help recovering or have other special health needs	Home health care	\$0	\$0	You may have coverage for this service under the Alternate Coverage, but not under this plan. This plan reimburses for eligible co-pays, co-insurance and deductibles incurred under the Alternate Coverage up to the ACA limits per year as follows: 100% for all North Oaks billed services and 75% for all Non-North Oaks billed services. Any procedure not covered by the Alternate Coverage will not be reimbursed under this plan.
	Rehabilitation services	\$0	\$0	
	Habilitation services	\$0	\$0	
	Skilled nursing care	\$0	\$0	
	Durable medical equipment	\$0	\$0	
	Hospice services	\$0	\$0	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses			
	Children's dental check-up			

* For more information about limitations and exceptions, see the [plan](#) or policy document.

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 | • Hearing aids | • Private-duty nursing |
| • Any expense payable through another source (such as the Alternate Coverage) | • Infertility treatment | • Routine eye care (adult) |
| • Bariatric surgery | • Long-term care | • Routine foot care |
| • Cosmetic Surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

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

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|--|--|---|
| • Chiropractic care (This plan does not reimburse for expenses not paid by the Alternate Coverage) | • Dental care (Adult) (This plan does not reimburse for expenses not paid by the Alternate Medical Coverage) | • |
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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: 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Catilize Health at 877-872-4232.

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? No, however, this plan is integrated with a group health plan that may meet the minimum value standards. 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](#).

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](#) \$N/A
- [Specialist \[cost sharing\]](#) \$N/A
- Hospital (facility) [\[cost sharing\]](#) %N/A
- Other [\[cost sharing\]](#) %N/A

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:

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

This plan does not cover specific services, it only pays for eligible co-pays, co-insurance and deductibles up to the amount available in the MERP

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$N/A
- [Specialist \[cost sharing\]](#) \$N/A
- Hospital (facility) [\[cost sharing\]](#) %N/A
- Other [\[cost sharing\]](#) %N/A

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:

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

This plan does not cover specific services, it only pays for eligible co-pays, co-insurance and deductibles up to the amount available in the MERP

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$N/A
- [Specialist \[cost sharing\]](#) \$N/A
- Hospital (facility) [\[cost sharing\]](#) %N/A
- Other [\[cost sharing\]](#) %N/A

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:

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

This plan does not cover specific services, it only pays for eligible co-pays, co-insurance and deductibles up to the amount available in the MERP

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