



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, go to www.summit-inc.net or call 888-690-2020. 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 <https://www.healthcare.gov/sbc-glossary> or call 888-690-2020 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 ?	Yes	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
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 ?	Yes. This plan uses the IMS panel of providers. See www.summit-inc.net or call 1-888-690-2020 for a list of Panel Providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from the provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware that 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 ?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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	\$5 copayment /visit	Not Covered	None 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.
	Specialist visit	\$5 copayment /visit	Not Covered	
	Preventive care/screening/immunization	\$5 copayment /visit	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	\$5 copayment /visit	Not Covered	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. None
	Imaging (CT/PET scans, MRIs)	\$25 copayment /visit	Not Covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.smithrx.com .	Generic drugs	Retail \$2 copayment	Not Covered	None
	Preferred brand drugs	Retail \$5 copayment		None
	Non-preferred brand drugs	Not Covered		Not covered
	Specialty drugs	Not Covered		Not Covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 copayment	Not Covered	None
	Physician/surgeon fees	\$0	Not Covered	None
If you need immediate medical attention	Emergency room care (Mex)	\$10 copayment	\$10 copayment	None ER Services in the U.S. shall only be covered in cases of sudden onset of a medical or traumatic condition, that if not treated immediately, could lead to serious harm, impairment of bodily functions, or dysfunction of a bodily organ.
	Emergency room care (U.S)	\$3,000 deductible then 20% coinsurance	\$3,000 deductible then 20% coinsurance	

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	\$100 copay then 20% coinsurance	\$100 copay then 20% coinsurance	None
	Urgent care	\$10 copayment	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$50 copay	Not Covered	None
	Physician/surgeon fees	\$0	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 copayment /visit	Not Covered	None
	Inpatient services	\$50 copayment	Not Covered	None
If you are pregnant	Office visits	\$5 copayment / visit	Not Covered	None
	Childbirth/delivery professional services	\$50 copayment /visit	Not Covered	None
	Childbirth/delivery facility services	\$50 copayment /visit	Not Covered	None
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	None
	Rehabilitation services	\$5 copayment /visit	Not Covered	None
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Not Covered	Not Covered	None
	Durable medical equipment	\$5 copayment /visit	Not Covered	None
	Hospice services	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	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 .)		
<ul style="list-style-type: none"> Acupuncture Bariatric Surgery for Morbid Obesity Chiropractic Care Cosmetic Surgery 	<ul style="list-style-type: none"> Hearing Aids Infertility Treatment Long-term Care Dependent Child Pregnancy 	<ul style="list-style-type: none"> Private Duty Nursing Routine Eye Care (Adult) Routine Foot Care

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- [Habilitation services](#)
- Weight Loss Programs (Except as required by ACA)

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

- Dental Care (Adult)
- Non-Emergency Care while Traveling outside of Mexico

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, 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: www.dol.gov/ebsa/healthreform for more information.

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 1-888-690-2020.

Para ver ejemplos de cómo este [plan](#) podría cubrir los costos de una situación médica de ejemplo, consulte la siguiente sección.

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	\$0
■ Specialist copayment	\$5
■ Hospital (facility) copayment	\$50
■ Other copayment	\$5

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	\$
Copayments	\$60
Coinsurance	\$
What isn't covered	
Limits or exclusions	\$
The total Peg would pay is	\$60

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 copayment	\$5
■ Hospital (facility) copayment	\$50
■ Other copayment	\$10

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	\$
Copayments	\$65
Coinsurance	\$
What isn't covered	
Limits or exclusions	\$
The total Joe would pay is	\$65

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$5
■ Hospital (facility) copayment	\$50
■ Other copayment	\$10

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	\$
Copayments	\$70
Coinsurance	\$
What isn't covered	
Limits or exclusions	\$
The total Mia would pay is	\$70

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