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 1-844-660-2288 or visit us at mybenefits.marpaihealth.com. 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 1-844-660-2288 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Provider: **$1,500** Individual/**$3,000** Family Out-of-network Provider: **$5,000** Individual/**$10,000** Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services and certain services with copayments are covered before you meet the deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. 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 must pay all of the costs for brand name prescriptions up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network provider: **$3,500** Individual/**$7,000** Family Out-of-network provider: **$10,000** Individual/**$20,000** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Precertification program penalties, charges in excess of allowable expenses, premiums, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See mybenefits.marpaihealth.com or call 1-844-660-2288 for a list of network 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 a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

		(such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		PPO Provider (You will pay the least)	Non-PPO 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	$20 copay/visit; deductible does not apply	50% coinsurance	None.
	Specialist visit	$40 copay/visit; deductible does not apply	50% coinsurance	None.
	Preventive care/screening/ immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventative. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.liviniti.com	Generic drugs	Retail/Mail Order (1-30-day supply) : $10 copay; deductible does not apply Retail/Mail Order (31-90-day supply): $20 copay; deductible does not apply		None.
	Preferred brand drugs	Retail/Mail Order (1-30-day supply) : $35 copay; deductible does not apply Retail/Mail Order (31-90-day supply): $70 copay; deductible does not apply		
	Non-preferred brand drugs	Retail/Mail Order (1-30-day supply) : $60 copay; deductible does not apply Retail/Mail Order (31-90-day supply): $120 copay; deductible does not apply		
	Specialty drugs	$175 copay; deductible does not apply		None.

* For more information about limitations and exceptions, see the plan or policy document at mybenefits.Marpaihealth.com. .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	$250 copay; deductible does not apply	$250 copay; deductible does not apply	None.
	Emergency medical transportation	30% coinsurance	30% coinsurance	None.
	Urgent care	$40 copay; deductible does not apply	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit; 30% coinsurance for additional services	50% coinsurance	None.
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
If you are pregnant	Office visits	$20 copay; deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a [copayment, coinsurance, or deductible] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other	Home health care	30% coinsurance	50% coinsurance	Limited to 60 visits per benefit period. Preauthorization may be required. If you don't

* For more information about limitations and exceptions, see the plan or policy document at mybenefits.Marpaihealth.com. .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
special health needs				get preauthorization, benefits could be reduced by $500 per occurrence.
	Rehabilitation services	30% coinsurance	50% coinsurance	Limited to 60 days per benefit period. Preauthorization may be required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
	Habilitation services	30% coinsurance	50% coinsurance	See rehabilitation limitations.
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 120 days per benefit period. Preauthorization may be required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
	Durable medical equipment	30% coinsurance	50% coinsurance	Preauthorization may be required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
	Hospice services	30% coinsurance	50% coinsurance	Limited to 60 visits per benefit period. Preauthorization may be required. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	An eye exam as a separate visit outside of pediatric preventive care is not covered.
	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.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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	• Hearing Aids	• Weight loss program

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 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: Marpai Health at 1-844-660-2288 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants.

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 1-844-660-2288.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-660-2288.
Chinese (**中文**): **如果需要中文的帮助，** 请拨打这个号码 1-844-660-2288.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-660-2288.

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	$1500
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1500
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1500
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

The plan would be responsible for the other costs of these EXAMPLE covered services.