



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, see www.kbasolution.com or call 877-851-0906. 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 1-877-851-0906 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. Preventive care services are covered before you meet your 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 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.	This plan does not use a provider network. You can receive covered services from any provider .
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	None
	Specialist visit	Not covered	None
	Preventive care/screening /immunization	No charge	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	None
	Imaging (CT/PET scans, MRIs)	Not covered	
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Not covered	None
	Preferred brand drugs (Tier 2)	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	
	Specialty drugs (Tier 4)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	None
	Physician/surgeon fees	Not covered	
If you need immediate medical attention	Emergency room care	Not covered	None
	Emergency medical transportation	Not covered	None
	Urgent care	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	None
	Physician/surgeon fees	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	None
	Inpatient services	Not covered	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	No charge for preventive services. Other office visits not covered.	Cost sharing does not apply for preventive services . No coverage for services that are not preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	Not covered	
	Childbirth/delivery facility services	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	None
	Rehabilitation services	Not covered	
	Habilitation services	Not covered	
	Skilled nursing care	Not covered	
	Durable medical equipment	Not covered	
	Hospice services	Not covered	
If your child needs dental or eye care	Children's eye exam	Not covered	None
	Children's glasses	Not covered	
	Children's dental check-up	Not covered	

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 • Childbirth Services • Chiropractic Care • Cosmetic Surgery • Dental Care • Durable Medical Equipment • Emergency Care • Habilitation Services	• Hearing Aids • Home Health Care • Hospice Services • Hospital Stays • Infertility Treatment • Long Term Care • Mental Health Services • Non-emergency care when traveling outside the U.S.	• Outpatient Surgeries • Prescription Drugs • Private Duty Nursing • Rehabilitation Services • Routine Eye Care (Adult) • Routine Foot Care • Skilled Nursing Care • Termination of pregnancy, except in limited circumstances • Testing Services
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• 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 Plan at 877-851-0906 or www.kbasolution.com; US Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa; or the US Department of Health and Human Services at 877-267-2323 ext.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 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: Key Benefit Administrators at 877-851-0906 or Employee Benefits Security Administration at 866-444-3272 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 the Minimum Value Standards? No.

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 877-851-0906.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-851-0906.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 877-851-0906.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 877-851-0906.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 877-851-0906 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 877-851-0906.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 877-851-0906.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 877-851-0906.

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	\$0
■ Specialist coinsurance	100%
■ Hospital (facility) coinsurance	100%
■ Other coinsurance	100%

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	\$0
Copayments	\$0
Coinsurance	\$0

What isn't covered	
Limits or exclusions	\$12,700
The total Peg would pay is	\$12,700

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 coinsurance	100%
■ Hospital (facility) coinsurance	100%
■ Other coinsurance	100%

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	\$0
Copayments	\$0
Coinsurance	\$0

What isn't covered	
Limits or exclusions	\$5,600
The total Joe would pay is	\$5,600

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist coinsurance	100%
■ Hospital (facility) coinsurance	100%
■ Other coinsurance	100%

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	\$0
Copayments	\$0
Coinsurance	\$0

What isn't covered	
Limits or exclusions	\$2,800
The total Mia would pay is	\$2,800

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