**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services **Coverage Period: 01/01/2024-12/31/2024**

**County of Callaway Employee Benefits Plan: PPO Plan Coverage for: Individual/Family | Plan Type: PPO**

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| Picture of exclamation point to label important information**The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan.**](https://www.healthcare.gov/sbc-glossary/#plan) **The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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 1-312-906-8080 or go to [www.alliedbenefit.com](http://www.alliedbenefit.com). For general definitions of common terms, such as [allowed amount,](https://www.healthcare.gov/sbc-glossary/#allowed-amount) [balance billing,](https://www.healthcare.gov/sbc-glossary/#balance-billing) [coinsurance,](https://www.healthcare.gov/sbc-glossary/#coinsurance) [copayment,](https://www.healthcare.gov/sbc-glossary/#copayment) [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider,](https://www.healthcare.gov/sbc-glossary/#provider) or other underlined terms, see the Glossary. [www.alliedbenefit.com](http://www.alliedbenefit.com) or call 1-312-906-8080 to request a copy. |

| **Important Questions** | **Answers** | **Why This Matters:** |
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| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | For [network providers](https://www.healthcare.gov/sbc-glossary/#network-provider) $1,250 person / $3,750 family; for [out-](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) providers $2,500 person / $7,500 family | Generally, you must pay all of the costs from [providers](https://www.healthcare.gov/sbc-glossary/#provider) up to the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan) begins to pay. If you have other family members on the [plan,](https://www.healthcare.gov/sbc-glossary/#plan) each family member must meet their own individual [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) until the total amount of [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) expenses paid by all family members meets the overall family [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). |
| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | Yes. Prescription drugs, in-network [preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care), routine eye exams, in-network physician/specialist visits, in-network urgent care visits, in-network physical/occupational/speech therapy, outpatient chemotherapy and radiation, outpatient/office/independent laboratory routine and diagnostic tests, radiology and pathology administration and interpretation services, and renal dialysis are covered before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers some items and services even if you haven’t yet met the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount. But a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. For example, this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers certain [preventive](https://www.healthcare.gov/sbc-glossary/#preventive-care) [services](https://www.healthcare.gov/sbc-glossary/#preventive-care) without [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) and before you meet your [deductible.](https://www.healthcare.gov/sbc-glossary/#deductible) See a list of covered [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) at [https://www.healthcare.gov/coverage/preventive-care-benefits/.](https://www.healthcare.gov/coverage/preventive-care-benefits/) |
| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | There are no other specific [deductibles](https://www.healthcare.gov/sbc-glossary/#deductible). | You don’t have to meet [deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) for specific services. |
| **What is the** [**out-of-pocket**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)[**limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | For [network providers](https://www.healthcare.gov/sbc-glossary/#network-provider) $4,500 individual / $13,500 family; Unlimited for [out-](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) [of-network](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) providers | The [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#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,](https://www.healthcare.gov/sbc-glossary/#plan) they have to meet their own [out-of-pocket limits](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) until the overall family [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) has been met. |
| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | Penalties for failure to obtain precertification/preauthorization, services in excess of Plan maximums or limits, [premiums](https://www.healthcare.gov/sbc-glossary/#premium), [balance-billing](https://www.healthcare.gov/sbc-glossary/#balance-billing) charges, and health care this [plan](https://www.healthcare.gov/sbc-glossary/#plan)doesn’t cover. | Even though you pay these expenses, they don’t count toward the [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit). |
| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. See [www.alliedbenefit.com](http://www.alliedbenefit.com) or call 1-312-906-8080 for a list of [network providers](https://www.healthcare.gov/sbc-glossary/#network-provider). | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) uses a [provider](https://www.healthcare.gov/sbc-glossary/#provider) [network](https://www.healthcare.gov/sbc-glossary/#network). You will pay less if you use a [provider](https://www.healthcare.gov/sbc-glossary/#provider) in the [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) [network.](https://www.healthcare.gov/sbc-glossary/#network) You will pay the most if you use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider), and you might receive a bill from a [provider](https://www.healthcare.gov/sbc-glossary/#provider) for the difference between the [provider’s](https://www.healthcare.gov/sbc-glossary/#provider) charge and what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) pays [(balance](https://www.healthcare.gov/sbc-glossary/#balance-billing) [billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). Be aware, your [network provider](https://www.healthcare.gov/sbc-glossary/#network-provider) might use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) for some services (such as lab work). Check with your [provider](https://www.healthcare.gov/sbc-glossary/#provider) before you get services. |
| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | No. | [You can see the [specialist](https://www.healthcare.gov/sbc-glossary/#specialist) you choose without a [referral](https://www.healthcare.gov/sbc-glossary/#referral)**.**](https://www.healthcare.gov/sbc-glossary/#specialist) |

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| Picture of exclamation point to label important informationAll [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) and [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [**deductible**](https://www.healthcare.gov/sbc-glossary/#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)**  *Note: Generally, payment of Out-of-Network professional services will be limited to 135% of the Medicare fee schedule, and payment of Out-of-Network facility services will be limited to 175% of the Medicare fee schedule. Some exceptions may apply. See the “Out-of-Network Benefits” section of the SPD for more information.* |
| **If you visit a health care** [**provider’s**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** | Primary care visit to treat an injury or illness | $30 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/office visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply; $15 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/chiropractic visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply; $30 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) for outpatient chemotherapy and radiation, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply; and 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) for other physician services | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Does not include DME and Orthotics. Limited to general practice, family practice, OB/GYN, internal medicine, osteopaths, pediatricians, nurse practitioners, physician assistants and mental health providers.  Chiropractic coverage is limited to 20 visits. [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is recommended for radiation treatments and chemotherapeutic drugs. See Plan Document for other services. |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | $60 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/office visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Does not include DME and Orthotics. See Plan Document for other services. |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/  immunization | No charge, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Routine labs and x-rays are covered for Callaway County Health Department and Quest Diagnostics at no charge.  You may have to pay for services that aren’t preventive. Ask your [provider](https://www.healthcare.gov/sbc-glossary/#provider) if the services needed are preventive. Then check what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay for. |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | $30 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) per service, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Does not include emergency room diagnostic services. No charge, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply for services performed at Callaway County Health Department and Quest Diagnostics. |
| Imaging (CT/PET scans, MRIs) | $30 [copay](https://www.healthcare.gov/sbc-glossary/#copayment) per service, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is recommended for certain services. |
| **If you need drugs to treat your illness or condition**  More information about [**prescription drug** **coverage**](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage) is available at [www.smithrx.com](http://www.smithrx.com) | Generic drugs (Tier 1) | $10 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/prescription (retail) $30 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/prescription (extended retail and mail-order) | | Covers up to a 30-day supply (retail prescription); 90-day supply (extended retail and mail order prescription). [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. Once the Out-of-Pocket Maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year.  \*See Plan Document for non-use of generic drug penalty. |
| Preferred brand drugs (Tier 2) and Non-preferred brand drugs (Tier 3) | $50 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/prescription (retail) $150 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/prescription (extended retail and mail-order) | |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) (Tier 4) | 25% [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/prescription | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is recommended for certain services. |
| Physician/surgeon fees | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Paid same as in-network | None |
| [Emergency medical](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) [transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is recommended for certain services. |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | $30 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/office visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Does not include DME and Orthotics. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is recommended |
| Physician/surgeon fees | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/office visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply, and 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) for other outpatient services | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | None |
| Inpatient services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you are pregnant** | Office visits | $30 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/office visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) does not apply for [preventive](https://www.healthcare.gov/sbc-glossary/#preventive-care) [services](https://www.healthcare.gov/sbc-glossary/#preventive-care). Depending on the type of services, a [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is recommended |
| Childbirth/delivery professional services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| Childbirth/delivery facility services | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 60 visits per calendar year. [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is recommended |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | $15 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | Physical and occupational therapy: limited to a combined maximum of 20 visits of office and outpatient facility services per calendar year. Speech therapy: limited to 20 visit maximum per calendar year. |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | $15 [copay](https://www.healthcare.gov/sbc-glossary/#copayment)/visit, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 60 days per calendar year. [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is recommended |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is recommended for certain services. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | 20% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | 40% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | [Preauthorization](https://www.healthcare.gov/sbc-glossary/#preauthorization) is recommended |
| **If your child needs dental or eye care** | Children’s eye exam | No charge, [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply | Not covered | Applies from birth through age 5. |
| Children’s glasses | Not covered | Not covered | Not covered. |
| Children’s dental check-up | Not covered | Not covered | Not covered. |

**Excluded Services & Other Covered Services:**

| **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | |
| --- | --- | --- |
| * Cosmetic Surgery * Dental Care (Adult) * Dental check-ups (Child) | * Glasses (Child) * Long Term Care | * Non-emergency care when traveling outside the U.S. * Routine Foot Care |

| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** | | |
| --- | --- | --- |
| * Acupuncture * Bariatric Surgery (limited to 1 procedure per lifetime) | * Chiropractic Care (limited to 20 visits per calendar year) * Hearing Aids (limited to one hearing aid per hearing impaired ear every 3 Calendar Years * Infertility treatment (except promotion of conception) | * Private-duty nursing (limited to 60 visits (one per day) per calendar year) * Routine eye care (Adult) - limited to one exam per Calendar Year. * Weight Loss Programs (non-surgical obesity treatment limited to $5,000 per lifetime) |

**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-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace) For more information about the [Marketplace,](https://www.healthcare.gov/sbc-glossary/#marketplace) visit [www.HealthCare.gov](http://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](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim.](https://www.healthcare.gov/sbc-glossary/#claim) This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal.](https://www.healthcare.gov/sbc-glossary/#appeal) For more information about your rights, look at the explanation of benefits you will receive for that medical [claim.](https://www.healthcare.gov/sbc-glossary/#claim) Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information on how to submit a [claim,](https://www.healthcare.gov/sbc-glossary/#claim) [appeal,](https://www.healthcare.gov/sbc-glossary/#appeal) or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan.](https://www.healthcare.gov/sbc-glossary/#plan) For more information about your rights, this notice, or assistance, contact: the Plan Administrator at 573-642-0750 or the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage?** **Yes.**

[Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) generally includes [plans](https://www.healthcare.gov/sbc-glossary/#plan), [health insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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,](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) you may not be eligible for the [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits).

**Does this plan meet the Minimum Value Standards?** **Yes.**

If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards,](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard) you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace.](https://www.healthcare.gov/sbc-glossary/#marketplace)

***To see examples of how this*** [***plan***](https://www.healthcare.gov/sbc-glossary/#plan) ***might cover costs for a sample medical situation, see the next section.***

**About these Coverage Examples:**

|  |
| --- |
| Picture of exclamation point to label important information**This is not a cost estimator.** Treatments shown are just examples of how this [plan](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost-sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts ([deductibles](https://www.healthcare.gov/sbc-glossary/#deductible), [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). 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](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $1,250

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) $60

◼ Hospital (facility) [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) 20%

◼ Other [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) 20%

**This EXAMPLE event includes services like:**

[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) office visits *(prenatal care)*

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(ultrasounds and blood work)*

[Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
| --- | --- |
| **In this example, Peg would pay:** |  |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $1,250 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $0 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $2,000 |
| *What isn’t covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,310** |

**Managing Joe’s Type 2 Diabetes** (a year of routine in-network care of a well- controlled condition)

* The [plan’s](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $1,250

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) $60

◼ Hospital (facility) [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) 20%

◼ Other [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) 20%

**This EXAMPLE event includes services like:**

[Primary care physician](https://www.healthcare.gov/sbc-glossary/#primary-care-physician) office visits *(including disease education)*

[Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(blood work)*

[Prescription drugs](https://www.healthcare.gov/sbc-glossary/#prescription-drug-coverage)

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(glucose meter)*

| **Total Example Cost** | **$5,600** |
| --- | --- |
| **In this example, Joe would pay:** |  |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $0 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $1,700 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan) overall [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) $1,250

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) $60

◼ Hospital (facility) [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) 20%

◼ Other [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) 20%

**This EXAMPLE event includes services like:**

[Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) *(including medical supplies)*

[Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (*x-ray*)

[Durable medical equipment](https://www.healthcare.gov/sbc-glossary/" \l "durable-medical-equipment) *(crutches)*

[Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) *(physical therapy)*

| **Total Example Cost** | **$2,800** |
| --- | --- |
| **In this example, Mia would pay:** |  |
| *Cost Sharing* | |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $1,250 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $200 |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $100 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,550** |

The [plan](https://www.healthcare.gov/sbc-glossary/#plan) would be responsible for the other costs of these EXAMPLE covered services.