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, [insert contact information]. 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.geobluestudents.com or call 1-844-268-2686 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network – $250 individual/ $500 family. Inside the U.S., Out of Network - $250 individual/ $500 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary 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?	Yes. $500 for Dental Expenses applicable to Participants through age 18.	You must pay all of the costs for these services 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?	In Network- $5,000 individual/ $10,000 family. Inside the U.S., Out of Network- $5,000 individual/ $10,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, deductibles, 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 www.geobluetuents.com or call 1-844-268-2686 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 (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You do no need to have a referral under this plan before you see a 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	$10 copay/visit; deductible does not apply	50% coinsurance	None
	Specialist visit	$10 copay/visit; deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	50% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	$20 copay/ prescription per 30-day supply, no deductible	$20 copay/ prescription per 30-day supply, no deductible	Up to a 90-day supply available at participating provider. Mail order prescriptions available. Non-participating mail order pharmacy not covered.
	Preferred brand drugs	$50 copay/ prescription per 30-day supply, no deductible	$50 copay/ prescription per 30-day supply, no deductible	Up to a 90-day supply available at participating provider. Mail order prescriptions available. Non-participating mail order pharmacy not covered.
	Non-preferred brand drugs	$50 copay/ prescription per 30-day supply, no deductible	$50 copay/ prescription per 30-day supply, no deductible	Up to a 90-day supply available at participating provider. Mail order prescriptions available. Non-participating mail order pharmacy not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% coinsurance	None
	Physician/surgeon fees	No charge	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay per visit – waived if admitted	$250 copay per visit – waived if admitted, then	None

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

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)	
			50% coinsurance	
	Emergency medical transportation	No charge	50% coinsurance	None
	Urgent care	No charge	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% coinsurance	None
	Physician/surgeon fees	No charge	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/visit; deductible does not apply	50% coinsurance	None
	Inpatient services	No charge	50% coinsurance	None
If you are pregnant	Office visits	$10 copay/visit; deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	50% coinsurance	
	Childbirth/delivery facility services	No charge	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	120 visits/Policy Year
	Rehabilitation services	$10 copay/visit; deductible does not apply	50% coinsurance	Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$10 copay/visit; deductible does not apply	50% coinsurance	
	Skilled nursing care	No charge	50% coinsurance	120 visits/Policy Year
	Durable medical equipment	No charge	50% coinsurance	None
	Hospice services	No charge	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No Charge		Limited to one exam per Policy Year
	Children's glasses	No Charge		Limited to one set of lenses per year and up to $200 for frames
	Children's dental check-up	No Charge		Limited to 2 exams per policy year

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

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.)		
• Cosmetic surgery • Dental care (Adult)	• Infertility treatment • Long-term care	• Routine eye care (Adult) • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (if prescribed for rehabilitation purposes) • Bariatric surgery • Chiropractic care	• Coverage provided outside the United States. See www.geobluestudents.com • Dental care (Children) • Hearing aids (limitations apply)	• Non-emergency care when traveling outside the U.S. • Private-duty nursing (limitations apply) • Routine eye care (Children)

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

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: California Department of Insurance, 300 South Spring Street, Los Angeles, California 90013. 1-800-927-4357 in CA. 1-213-897-8921 out of CA. 1-800-482-4833 Telecommunication Device for the Deaf. 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: [insert applicable contact information from instructions].

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 1-844-268-2686.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-268-2686.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-268-2686.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-268-2686.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

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

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	**$250**
Specialist *[cost sharing]*	**$10**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**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	$250
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$320**

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

The plan's overall deductible	**$250**
Specialist *[cost sharing]*	**$10**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**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	$250
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$770**

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

The plan's overall deductible	**$250**
Specialist *[cost sharing]*	**$10**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**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	$250
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

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