**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services **Coverage Period: 01/01/ 2025 – 12/31/2026**

NYSUT Member Benefits Catastrophe Major Medical (CMM) Insurance Trust Plan **Coverage for: Individual/Family| Plan Type: Catastrophic Major Medical**

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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 844-552-7805. 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. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 844-552-7805 to request a copy. |

| **Important Questions** | **Answers** | **Why This Matters:** |
| --- | --- | --- |
| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | In-network providers under Basic Plan: $2,000/individual or $4,000/familyOut-of-network providers under Basic Plan: $5,000/individual Does not apply to the Critical Illness Benefit. | 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**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | Yes. Preventive care, Critical Illness, Convalescent/Custodial Care, Nursing Home, Assisted Living Facilities and Home Health Care benefits 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**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | No | You don’t have to meet deductibles 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)**?** | In-network providers under Basic Plan: $2,000/individual, $4,000/family; Out-of-network providers under Basic Plan: No limit | The out-of-pocket limit is the most you could pay in a year for covered services involving essential health benefits. 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**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | Premiums, balance-billing charges, health care this plan doesn’t cover, non-essential health benefits including private duty nursing, custodial care in a skilled nursing facility, and care in a convalescent home, custodial care facility, nursing home, or assisted living facility, expenses for services from out-of-network providers under your Basic Plan, and care for which you fail to obtain pre-authorization required under your Basic Plan. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |

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| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | Yes. See the website for your Basic Plan or call your Basic Plan for a list of its in-network providers. | You will pay less if you use a provider who is in-network under your Basic Plan. You will pay the most if you use an out-of-network provider under your Basic Plan, and you might receive a bill from a provider for the difference between the provider’s charge and what your Basic 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**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | Yes | If a referral is required by your Basic Plan, 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. |
| 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****under Basic Plan****(You will pay the least)** | **Out-of-Network Provider****under Basic Plan****(You will pay the most)**  |
| **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 | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges | Acupuncture and chiropractic services limited to 30 visits each per calendar year. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges |
| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/immunization | No charge. Deductible does not apply. | No charge. Deductible does not apply. | Age and frequency limitations apply. 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. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| **If you have a test** | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges | This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| Imaging (CT/PET scans, MRIs) | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges |
| **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 from the administrator, HealthSmart Benefit Solutions, at 844-552-7805 | Generic drugs | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges | This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| Preferred brand drugs | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges |
| Non-preferred brand drugs | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges |
| [Specialty drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges | This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| Physician/surgeon fees | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges |
| **If you need immediate medical attention** | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges | This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges | Only the cost of a semi-private room is covered unless a private room is determined (by the Administrator or its designee) to be Medically Necessary. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan.\*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| Physician/surgeon fees | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges | This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges | This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| Inpatient services | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges |
| **If you are pregnant** | Office visits | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges | This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| Childbirth/delivery professional services | Amounts over Covered Charges |  30% coinsurance plus amounts over Covered Charges |
| Childbirth/delivery facility services | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges |
| **If you need help recovering or have other special health needs** | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | Amounts over Covered Charges | 70% coinsurance plus amounts over Covered Charges | Benefits begin following 60 hours of paid home health care per calendar year; maximum 25 hours per week; limited to 6,000 hours per lifetime while covered under this Plan. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. Refer to the Plan Document for the definition of Home Health Care Agencies that are considered In-Network under the Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the Plan Document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges | Physical therapy, speech therapy, and occupational therapy in the outpatient department of a facility or in a provider’s office up to combined 30 visits per calendar year. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | Amounts over Covered Charges | For active and progressive treatment, 30% coinsurance plus amounts over Covered Charges.  | Coverage for active and progressive treatment in a skilled nursing facility or subacute care facility up to 100 days while covered under this Plan. Private Duty Nursing (up to $15 per hour ($360/day) and maximum of $35,000 while covered under this Plan). This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges | Covers artificial limbs, crutches, wheelchairs and other medical equipment, appliances and supplies as medically necessary. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | Amounts over Covered Charges | 30% coinsurance plus amounts over Covered Charges | Limited to 210 consecutive days of confinement per lifetime while covered under this Plan and 5 visits per lifetime while covered under this Plan for bereavement counseling to the family of the terminally ill participant. This Plan will pay Covered Charges, less whatever payments were made by the Basic Plan(s), up to any applicable maximums and subject to any coinsurance requirements. No benefits are payable if you are not enrolled in a Basic Plan at the time the claim is incurred. This Plan considers in-network providers under your Basic Plan to be in-network under this Plan. \*See the Benefits, Exclusions and Limitations and Coordination of Benefits sections of the plan document for a definition of Covered Charges and more information on how benefits are calculated under this Plan. |
| **If your child needs dental or eye care** | Children’s eye exam | Not covered | Not covered | You pay 100% of these expenses, even in-network.  |
| Children’s glasses | Not covered | Not covered | You pay 100% of these expenses, even in-network. |
| Children’s dental check-up | Not covered  | Not covered | You pay 100% of these expenses, even in-network. |

**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)**.)** |
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| * Cosmetic surgery (covered if result of non-occupational related injury or sickness or congenital disease or anomaly of a child resulting in functional defect)
 | * Dental Care (Adult and Child)
* Hearing Aids
* Non-emergency care when traveling outside the U.S.
 | * Routine Eye care (Adult & Child) (eye care, treatment or surgery covered if medically necessary and result of non-job related injury)
* Routine foot care
* Weight loss programs (except as required by the federal Affordable Care Act)
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| **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.)** |
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| * Acupuncture (if medically necessary; limited to 30 visits per calendar year)
* Bariatric surgery (if medically necessary)
* Chiropractic care (if medically necessary; limited to 30 visits per calendar year)
 | * Infertility Services (for diagnosis and treatment of medical conditions that result in infertility; expenses related to services that induce pregnancy are not covered)
 | * Long-Term care (covered charges for care in convalescent home/custodial care facility up to $72/day to maximum $80,000 while covered under this Plan; benefits begin on 20th day of confinement)
* Private duty nursing (Up to $15/hour ($360 per day); maximum of $35,000 while covered under this Plan).
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**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 at 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.](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 Administrator at 844-552-7805. You may also contact Department of Labor’s Employee Benefits Security Administration at

1-866-444-EBSA (3272) or [www.dol.gov/ebsa/](http://www.dol.gov/ebsa/)healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Department of Financial Services, One State Street, New York, NY 10004-1511; (800) 342-3736; <http://www.dfs.ny.gov/consumers>.

**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?**  **No**

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)

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 844-552-7805.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-552-7805.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-552-7805.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-552-7805.

***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:**

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| 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) $2,000

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) $0

◼ Hospital (facility) [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) $0

◼ Other [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) $0

**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** | **$12,800 ($240 remaining after Basic Plan pays)** |
| --- | --- |
| **In this example, Peg would pay:** |  |
| *Cost Sharing* |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $240 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $ |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $ |
| *What isn’t covered* |
| Limits or exclusions | $ |
| **The total Peg would pay is** | **$240** |

**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) $2,000

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) $0

◼ Hospital (facility) [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) $0

◼ Other [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) $0

**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-drugs)

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

| **Total Example Cost** | **$7,400 ($2,190 remaining after Basic Plan pays)** |
| --- | --- |
|  **In this example, Joe would pay:** |  |
| *Cost Sharing* |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) | $2,000 |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) | $ |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $ |
| *What isn’t covered* |
| Limits or exclusions | $ |
| **The total Joe would pay is** | **$2,000** |

**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) $2,000

◼ [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) $0

◼ Hospital (facility) [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) $0

◼ Other [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) $0

**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/#durable-medical-equipment) *(crutches)*

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

| **Total Example Cost** | **$1,970 ($1,250 remaining after Basic Plan pays)** |
| --- | --- |
| **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) | $ |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) | $ |
| *What isn’t covered* |
| Limits or exclusions | $ |
| **The total Mia would pay is** | **$1,250** |