**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, visit my.vitorihealth.com or call 1-844-925-9777. 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 1-800-318-2596 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $2,500/Individual or $5,000/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 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?** | $6,500/Individual or $13,000/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?** | Copayments, 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. *Members of Vitori Health are never responsible for paying a balance bill. If received, please contact the concierge number on the back of your ID card. |
| **Will you pay less if you use a network provider?** | Yes, it is possible that some providers in the network may bill at lower rates. | This plan uses a provider network for practitioners and urgent care, however, members are not restricted to this network. |
| **Do you need a referral to see a specialist?** | No | You can see the specialist you choose without 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 |
|---|---|---|---|---|
| | | 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 | $20 copay | Not Applicable | Virtual visits and telephonic visits are the same copay as in-office visits. Telephonic or video visits are available through *Teladoc* at no charge. |
| | Specialist visit | $40 copay | Not Applicable | None. |
| | Preventive care/screening/ immunization | No charge | Not Applicable | 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Deductible, then 20% coinsurance | Not Applicable | None. |
| | Imaging (CT/PET scans, MRIs) | Deductible, then 20% coinsurance | Not Applicable | Preauthorization is required or benefits may be reduced. |
| **If you need drugs to treat your illness or condition** For more information about **prescription drug coverage** contact Concierge at 1-844-925-9777. | Generic drugs (Tier 1) | Retail: $20 copay<br>Mail Order: $60 copay | Not Covered | Covers up to a 30-day supply (retail subscription)<br>Covers up to a 31–90-day supply (mail order prescription). |
| | Preferred brand drugs (Tier 2) | Retail: $65 copay<br>Mail Order: $195 copay | Not Covered | |
| | Non-preferred brand drugs (Tier 3) | Retail: $95 copay<br>Mail Order: $285 copay | Not Covered | |
| | Specialty drugs (Tier 4) | $200 copay | Not Covered | |

| 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Deductible, then 20% coinsurance | Not Applicable | Preauthorization is required or benefits may be reduced. ***Vitori Health Preferred Surgery Benefit is mandatory for Spine Surgery and Total Joint Replacement Surgery.*** |
| | Physician/surgeon fees | Deductible, then 20% coinsurance | Not Applicable | None. |
| **If you need immediate medical attention** | Emergency room care | $500 copay | $500 copay | None. |
| | Emergency medical transportation | Deductible, then no charge | Deductible, then no charge | |
| | Urgent care | $75 copay | Not Applicable | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $2,000 copay | Not Applicable | Preauthorization is required or benefits may be reduced. |
| | Physician/surgeon fees | Deductible, then no charge | Not Applicable | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge | Not Applicable | Preauthorization is required for Partial Day Program and Intensive Outpatient Programs. |
| | Inpatient services | Inpatient Physician: Deductible, then 20% coinsurance Inpatient Facility: $2,000 copay | Not Applicable | Preauthorization is required or benefits may be reduced. |
| **If you are pregnant** | Office visits | $20 copay | Not Applicable | Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | Deductible, then no charge | Not Applicable | |

| 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) | |
| | Childbirth/delivery facility services | $2,000 copay | Not Applicable | Failure to obtain preauthorization for childbirth if inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery may result in benefits being reduced. |
| **If you need help recovering or have other special health needs** | Home health care | Deductible, then no charge | Not Applicable | 120 visits/year combined with Private Duty Nursing home. |
| | Rehabilitation services | $40 copay | Not Applicable | 60 visits/year. Includes physical therapy, speech therapy, and occupational therapy.<br><br>Cardiac rehabilitation and respiratory therapies are 60 visits/year combined. |
| | Habilitation services | $40 copay | Not Applicable | None. |
| | Skilled nursing care | Physician Visit: Deductible, then no charge<br>Facility: $2,000 copay | Not Applicable | 60 visits/calendar year combined with Inpatient Medical Rehabilitation. |
| | Durable medical equipment | Deductible, then 20% coinsurance | Not Applicable | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.<br>Preauthorization is required above $2,500 or benefits may be reduced. |
| | Hospice services | Deductible, then no charge | Not Applicable | Preauthorization is required or benefits may be reduced. |
| **If your child needs dental or eye care** | Children's eye exam | No charge of the contracted/permitted rate. | Not Applicable | Coverage limited as required by PPACA. |
| | Children's glasses | No charge of the contracted/permitted rate. | Not Applicable | Coverage limited as required by PPACA. |
| | Children's dental check-up | No charge of the contracted/permitted rate. | Not Applicable | Coverage limited as required by PPACA. |

## 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.)**

- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Chiropractic care
- Hearing Aids
- Private-duty nursing

**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: your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or Affordable Care Act | U.S. Department of Labor (dol.gov) or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.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: 1-844-925-9777.

**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 1-844-925-9777

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-925-9777

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-925-9777

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-925-9777

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

## 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** **$2,500**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment** **$2,000**
- **Other coinsurance** **20%**

**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 | $2,500 |
| Copayments | $2,000 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$4,800** |

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$2,000**
- **Other coinsurance** **20%**

**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 | $100 |
| Copayments | $1,800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,900** |

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$2,000**
- **Other coinsurance** **20%**

**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 | $1,700 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,300** |

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