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 the 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, c

Common Medical Eve	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Network Provider Informatic
		Network Provider (You will pay the leas	Out-of-Network Provid (You will pay the most	
If you visit a health car provider's office or clinic	Zero Cost Telemedicine Partner	No charge	Not covered	Refer to your Evidence of Coverage
	Primary care visit to treat injury or illness.	$20 copay	Not covered	None
	Specialist visit	$60 copay	Not covered	None
	Preventive care/screening/immunizat	No charge	Not covered	You may have to pay for services tha preventive. Ask your provider if the se needed are preventive. Then check w your plan will pay for.
If you have a test†	Diagnostic test (x-ray, blo work)	X-ray: 25% coinsurance after deductible	Not covered	None
		Lab: $30 copay		None
	Imaging (CT/PET scans, MRIs)	25% coinsurance aft deductible	Not covered	None
If you need drugs to treat your illness or conditionto treat yo _____ _____ _____ _____				
	_____			
	_____			
	_____			
	_____			

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