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 www.geobluestudents.com or by calling 1-844-268-2686. 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?	$0/Individual outside of the U.S./$1,000 per Individual inside the U.S.	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?	No.	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?	For network providers $7,350 individual; for out-of-network providers $7,350 individual	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, 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.geobluestudents.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
		Outside the United States	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	No Charge	30% coinsurance	40% coinsurance	
	Specialist visit	No Charge	30% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	Not Covered	No charge, deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	No Charge	30% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance	40% coinsurance	Utilization review may apply.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.geobluestudents.com	Generic drugs	No Charge	$40 copay/prescription	$40 copay/prescription	Covers up to a 30-day supply (retail subscription). Deductible does not apply.
	Preferred Brand-name drugs	No Charge	$50 copay/prescription	$50 copay/prescription	
	Non-Preferred Brand-name drugs	No Charge	20% coinsurance	20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance	40% coinsurance	None
	Physician/surgeon fees	No Charge	30% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	No Charge	30% coinsurance	40% coinsurance	Out-of-Network emergency services are paid at the Network rate.
	Emergency medical transportation	No Charge	30% coinsurance	40% coinsurance	
	Urgent care	No Charge	30% coinsurance	40% coinsurance	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Outside the United States	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	30% coinsurance	40% coinsurance	Utilization review may apply.
	Physician/surgeon fees	No Charge	30% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	30% coinsurance	40% coinsurance	None
	Inpatient services	No Charge	30% coinsurance	40% coinsurance	
If you are pregnant	Office visits	No Charge	30% coinsurance	40% coinsurance	Cost sharing does not apply to certain 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	30% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	No Charge	30% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	40% coinsurance	40 visits/Policy year
	Rehabilitation services	No Charge	30% coinsurance	40% coinsurance	Includes physical therapy, speech therapy, and occupational therapy. Deductible does not apply to office visits. 60 visits per condition per Policy Year
	Habilitation services	No Charge	30% coinsurance	40% coinsurance	
	Skilled nursing care	No Charge	30% coinsurance	40% coinsurance	200 days/Policy year
	Durable medical equipment	No Charge	30% coinsurance	40% coinsurance	We do not Cover equipment designed for Your comfort or convenience
	Hospice services	Not Covered	30% coinsurance	40% coinsurance	Utilization review may apply.
If your child needs dental or eye care	Children's eye exam	Not Covered	No Charge		Limited to Insured Persons through age 18 and one exam per year.
	Children's glasses	Not Covered	No Charge		Limited to Insured Persons through age 18.
	Children's dental check-up	Not Covered	20% coinsurance		Limited to Insured Persons through age 18.

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 over age 19)
- Long Term Care
- Routine eye care (Adult over age 19)
- 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
- Hearing Aids (limitations apply)
- Non-emergency care when traveling outside the U.S.
- Infertility Treatment
- Private Duty Nursing (limited to 40 visits per Policy year under home health care)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the insurer at 1-844-268-2686. You may also contact your state insurance department at 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 to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can contact: Customer Service at 1-844-268-2686. Additionally, you can contact your plan administrator or California Department of Insurance, Claims Service Bureau, 11th Floor, 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.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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.geobluestudent.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	$1,000
Specialist copayment	$0
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$160
Coinsurance	$3,779
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,990**

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

The plan's overall deductible	$1,000
Specialist copayment	$0
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,890
Coinsurance	$359
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,305**

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

The plan's overall deductible	$1,000
Specialist copayment	$0
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$567
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,567**

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