




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, call 1-800-374-1835 or visit us at <http://www.nipponlifebenefits.com/member-service/ga-state-specific-requirements/>. 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.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-374-1835 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$500 member/\$1,000 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preferred Provider</a> services for <a href="#">preventive care</a> , physician office visits, urgent care, LabCard, emergency room visits and <a href="#">Preferred Provider</a> or <a href="#">Non-Preferred Provider</a> services for non-specialty prescription drugs and child preventive care are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">Preferred Provider</a> \$7,350 member/\$14,700 family; <a href="#">Non-Preferred Provider</a> \$14,700 member/\$29,400 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, penalties for failure to obtain <a href="#">pre-authorization</a> for services and the difference between the Generic Drug price and the Preferred or Non-	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

	Preferred Brand Name Drug price when a generic equivalent drug is available.	
Will you pay less if you use a <b>network provider</b> ?	Yes. See <a href="http://www.nipponlifebenefits.com/member-service/">http://www.nipponlifebenefits.com/member-service/</a> or call 1-800-374-1835 for a list of <a href="#">preferred providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <b>referral</b> to see a <b>specialist</b> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /office visit; <a href="#">deductible does not apply</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a> /office visit; <a href="#">deductible does not apply</a>	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible does not apply</a>	child immunizations to age 19 – no charge up to the <a href="#">allowed amount</a> ; excess not covered; other child care to age 6 – 30% <a href="#">coinsurance</a> ; persons age 6 or over - not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Non-office visits: 10% <a href="#">coinsurance</a> ; No charge for LabCard services	30% <a href="#">coinsurance</a> ; <a href="#">Emergency services</a> – 10% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> ; <a href="#">Emergency services</a> – 10% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.nipponlifebenefits.com/member-service/">prescription drug coverage</a> is available at <a href="http://www.nipponlifebenefits.com/member-service/">http://www.nipponlifebenefits.com/member-service/</a>	Generic drugs (Tier 1)	\$15 <a href="#">copay</a> /prescription (retail)	\$15 <a href="#">copay</a> /prescription + fee (retail)	<a href="#">Preferred Provider copay</a> does not apply to generic and single source contraceptives for women. Mail order <a href="#">copay</a> is twice retail. Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	\$30 <a href="#">copay</a> /prescription (retail)	\$30 <a href="#">copay</a> /prescription + fee (retail)	
	Non-preferred brand drugs (Tier 3)	\$50 <a href="#">copay</a> /prescription (retail)	\$50 <a href="#">copay</a> /prescription + fee (retail)	
	<a href="#">Specialty drugs</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /visit; <a href="#">deductible does not apply</a>	\$150 <a href="#">copay</a> /visit up to the <a href="#">allowed amount</a> , excess not covered	Imaging services and <a href="#">Non-Preferred Provider</a> non-emergency services subject to applicable <a href="#">deductible</a> and <a href="#">coinsurance</a> .
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a> /visit; <a href="#">deductible does not apply</a>	30% <a href="#">coinsurance</a>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Non-compliance penalty of 30% up to \$10,000.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copay</a> /office visit and 10% <a href="#">coinsurance</a> for other outpatient services	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for inpatient services. Non-compliance penalty of 30% up to \$10,000.
	Inpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you are pregnant</b>	Office visits	\$25 <a href="#">copay</a> /office visit	30% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	services			
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	100 visits/year
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copay</a> /office visit; 10% <a href="#">coinsurance</a> for other outpatient services	30% <a href="#">coinsurance</a>	30 visits/year. Includes physical, occupational and speech therapy.
	<a href="#">Habilitation services</a>	\$25 <a href="#">copay</a> /office visit; 10% <a href="#">coinsurance</a> for other outpatient services	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	120 days for same or related illness. <a href="#">Preauthorization</a> is required. Non-compliance penalty of 30% up to \$10,000.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Excludes motorized carts, scooters and strollers (except for wheelchairs), non-hospital type beds and lift chairs.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

#### 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](#).)

<ul style="list-style-type: none"> <li>Bariatric Surgery</li> <li>Cosmetic Surgery</li> <li>Dental Care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids</li> <li>Infertility Treatment</li> <li>Long Term Care</li> <li>Private Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care</li> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>
--	---	---

**Other Covered Services** (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

<ul style="list-style-type: none"> <li>Acupuncture up to \$500/year</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S. for up to 6 months except for medical travel</li> </ul>
--	---	---

**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:

- For group health coverage subject to ERISA, [Name of Group:      Address:      Telephone Number:    ]

- For group health coverage subject to ERISA, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

- For non-federal governmental group health plans, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

- Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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](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](#) 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 more information about your rights, this notice, or assistance, contact: the plan: English and Non-English 1-800-374-1835; Japanese 1-800-971-0638; Korean 1-800-827-8713 or Georgia Department of Insurance at 1-800-656-2298 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact 1-800-656-2298 or e-mail <http://www.oci.ga/consumerservice/home.aspx>.

**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 1-800-374-1835.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-374-1835.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [1-800-374-1835.

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-374-1835.

—————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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$ 12,800</b>
---------------------------	------------------

#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$100
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,660</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

#### In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$500
Copayments	\$1,100
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

#### In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$500
Copayments	\$400
Coinsurance	\$40
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$940</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [insert]. \*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.