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, contact Member Services at (855) 428-7284 or visit www.curative.com. 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 https://www.healthcare.gov/sbc-glossary or call (855) 428-7284 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	With Baseline Completion: $0 for network providers; $10,000 individual / $20,000 family for out-of-network providers. Without Baseline Completion: $5,000 individual / $10,000 family for network providers; $10,000 individual / $20,000 family for out-of-network providers. The Baseline Visit is a meeting with a Curative clinician to start your plan and talk about your health goals. Complete it within 120 days of your effective date to get the "With Baseline Completion" amounts. During your first 120 days in your first plan year, those amounts apply automatically when you use network providers. If you do not complete the visit within 120 days, the "Without Baseline Completion" amounts apply. You do not have to answer questions about disability or genetic information, or have a medical exam, to complete the visit.	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 and immunizations for children under the age of 6 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.

Important Questions	Answers	Why This Matters:
What is the out-of-pocket limit for this plan?	With Baseline Completion: For network providers $0 individual / $0 family. Copays for non-preferred drugs and non-preferred specialty drugs count toward a separate $7,500 individual / $15,000 family limit. For out-of-network providers $15,000 individual / $30,000 family. Without Baseline Completion: For network providers $12,000 individual / $24,000 family; for out-of-network providers $15,000 individual / $30,000 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?	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.curative.com or call (855) 428-7284 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 can see the specialist you choose without a 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 (With Baseline Completion. You will pay the least)	Network Provider (Without Baseline Completion. You will pay more)	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	$25 copay/visit	$50 copay/visit	None
	Specialist visit	No charge	$50 copay/visit	$100 copay/visit	None
	Preventive care/ screening/immunization	No charge	No charge	$50 copay/visit; no charge for immunizations for children under age 6	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (With Baseline Completion. You will pay the least)	Network Provider (Without Baseline Completion. You will pay more)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	50% coinsurance	Prior authorization is required.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at curative.com/drugs	Preferred drugs (generic, preferred brand and specialty drugs)	No charge	$50 copay/ prescription per 30-day supply	40% coinsurance per 30-day supply	Prior authorization may be required. If you don't get prior authorization, your drug may not be covered.
	Non-preferred drugs (non-preferred brand and generic drugs)	$50 copay/ prescription per 30-day supply	$100 copay/ prescription per 30-day supply	40% coinsurance per 30-day supply	With Baseline Completion, these copays count toward the plan's separate $7,500 individual / $15,000 family out-of-pocket limit.
	Non-preferred specialty drugs (specialty drugs)	$250 copay/ prescription per 30-day supply	25% coinsurance per 30-day supply	40% coinsurance per 30-day supply	With Baseline Completion, these copays count toward the plan's separate $7,500 individual / $15,000 family out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	50% coinsurance	Prior authorization is required.
	Physician/surgeon fees	No charge	20% coinsurance	50% coinsurance	Prior authorization is required.
If you need immediate medical attention	Emergency room care	No charge	20% coinsurance	No charge with Baseline Completion; 20% coinsurance without	None
	Emergency medical transportation	No charge	20% coinsurance	No charge with Baseline Completion; 20% coinsurance without	None
	Urgent care	No charge	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	50% coinsurance	Prior authorization is required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (With Baseline Completion. You will pay the least)	Network Provider (Without Baseline Completion. You will pay more)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge	20% coinsurance	50% coinsurance	Prior authorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$25 copay/visit for office visits; 20% coinsurance for other outpatient services	50% coinsurance	Prior authorization may be required for intensive outpatient treatment and partial hospitalization.
	Inpatient services	No charge	20% coinsurance	50% coinsurance	Prior authorization is required.
If you are pregnant	Office visits	No charge	20% coinsurance	50% coinsurance	Cost sharing does not apply for 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	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	No charge	20% coinsurance	50% coinsurance	Prior authorization is required.
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	50% coinsurance	Prior authorization is required.
	Rehabilitation services	No charge	20% coinsurance	50% coinsurance	Physical, occupational and speech therapy: up to 20 visits per plan year. More visits need prior authorization.
	Habilitation services	No charge	20% coinsurance	50% coinsurance	Physical, occupational and speech therapy: up to 20 visits per plan year. More visits need prior authorization.
	Skilled nursing care	No charge	20% coinsurance	50% coinsurance	Prior authorization is required.
	Durable medical equipment	No charge	20% coinsurance	50% coinsurance	Prior authorization is required for equipment costing more than $750. Standard manual and electric breast pumps are covered up to $500.
	Hospice services	No charge	20% coinsurance	50% coinsurance	Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (With Baseline Completion. You will pay the least)	Network Provider (Without Baseline Completion. You will pay more)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not covered	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.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 (20 visits per plan year)
- Bariatric surgery (once per lifetime)
- Chiropractic care (20 visits per plan year)
- Hearing aids (limits apply; see your plan document)

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: U.S. Department of Labor, Employee Benefits Security Administration, (866) 444-3272, www.dol.gov/ebsa/healthreform (for COBRA). 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: Curative Member Services, (855) 428-7284; U.S. Department of Labor, Employee Benefits Security Administration, (866) 444-3272, www.dol.gov/ebsa/healthreform; Florida Department of Financial Services, (877) 693-5236, www.myfloridacfo.com.

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 (855) 428-7284.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (855) 428-7284.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(855) 428-7284.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (855) 428-7284.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf (855) 428-7284 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni (855) 428-7284.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye (855) 428-7284.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang (855) 428-7284.

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

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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** **$0**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$20**

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

- **The plan's overall deductible** **$0**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

Note: These numbers assume the patient has completed the Baseline Visit. If you have not completed your Baseline Visit, your deductible, copayments and coinsurance will be higher (see the "Without Baseline Completion" amounts above).

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