

SUMMARY OF BENEFITS AND COVERAGE GUIDE

Every health insurance plan has a “Summary of Benefits and Coverage” document to help you understand which services and procedures are covered, and how much of the cost you’re likely to be responsible for. It also includes information about who to contact when you have questions or need more information.

This is the name of your plan

It includes:

- The metal level (Bronze)
- Your individual deductible (\$7,500)
- The plan type (HMO)
- The area serviced (New England)

This is your plan type

This plan’s type is a Health Maintenance Organization (HMO). HMO plans require you to have a primary care provider and get referrals to see specialists. If your plan is a Preferred Provider Organization (PPO), you can typically visit providers and specialists without a primary care provider referral.

INSURANCE PROVIDER NAME

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Name of Plan: **Clear Choice Bronze \$7500 HMO Tiered NE**

Coverage Period: 01/01/2026 through 12/31/2026

Coverage for: Individual and Family Plan Type: **HMO**

Summary of Benefits and Coverage (SBC) document will help you choose a health plan. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.insuranceprovider.com or call Member Services at **(800) 000-0000**.



How to reach your health insurance company

Call this number to reach your insurance company’s member services line. This number will also be on the back of your insurance card.

This is your deductible

This box shows you the deductible amount for your plan. Your deductible is the amount you need to pay for your health care before your health insurance company begins to pay for most covered services. You pay the deductible amount out-of-pocket, or from your own money. For this plan, the Preferred In-Network deductible for an individual is \$7,500, and the family deductible is \$15,000. This is the deductible that applies if you use preferred providers. The Standard In-Network individual deductible is \$9,000, and the family deductible is \$18,000. Some health care costs, such as copays and coinsurance, do not apply toward your deductible.

Important Questions	Answers	Why This Matters
What is the overall deductible?	Preferred In-Network: \$7,500 / individual or \$15,000 / family. Standard In-Network: \$9,000 / individual or \$18,000 / family.	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 (as defined in your Member Benefit Agreement). For more information, see below.	This plan covers some items and services even if you haven't yet met the deductible amount.

This is what's covered before you reach your deductible

This box covers pre-deductible coverage. All plans sold on CoverME.gov, including this one, have some pre-deductible coverage. Preventive care is included in pre-deductible coverage. Examples of preventive services are services you receive regularly when you're feeling well, like a routine pap smear or a mammogram at your well-woman visit. However, if you get a Pap smear or a mammogram when you have symptoms, such as a lump, it would be considered diagnostic rather than preventive. Diagnostic care is typically not included in pre-deductible coverage.



Deductibles for specific services

Sometimes plans may have separate deductibles for specific services (this plan does not). For example, if your plan says there is a \$300 deductible for prescription drug coverage, you'll need to pay \$300 towards prescription drugs before your insurance company will begin to cover some or all of your prescription drug costs.



Important Questions	Answers	Why This Matters
Are there other deductibles for specific services?	No.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
What is the out-of-pocket limit for this plan?	Preferred In-Network: \$9,200 / individual or \$18,400 / family. Standard In-Network: \$9,200 / individual or \$18,400 / family.	This plan covers some items and services even if you haven't yet met the deductible amount.

This is your out-of-pocket limit

The out-of-pocket limit is the maximum amount of money you could pay in a plan year for your deductibles, copays, and coinsurance for in-network care combined. The out-of-pocket limit does not include your monthly premium. For this plan, the out-of-pocket limit is \$9,200. Once you have paid that amount toward deductibles, copays, and coinsurance (for Preferred In-Network care and services), your health insurance company will pay 100% of the remaining Preferred In-Network costs. Just like your deductible, the out-of-pocket limit is typically lower when you use Preferred In-Network providers, and higher when you choose standard In-Network providers.

Common Medical Events

This list of common medical events is based on Essential Health Benefits. It provides a cost breakdown of commonly used medical services. In this section, you will see specific services, how much they cost, and any coverage limitations. **If you are getting a service that is not on this list, you will need to call your insurance company to ask about the costs and coverage limitations.**

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Preferred Network Provider (You will pay the rest)	Standard Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
Preventive care	Screening / Immunization	\$0 copay, deductible does not apply		Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive.

Preventive Care

If you need preventive care, such as STI testing or immunizations, it will be covered 100% by every in-network provider on this plan, regardless of their tier. There is no copay or out-of-pocket costs for preventive care, and you do not need to reach your deductible for it to be covered 100%.

However, preventive care, screenings, and immunizations are not covered at all if performed by out-of-network providers. Under this plan, if you receive out-of-network preventive care, you will be responsible for the full cost of that care. What you pay will not count towards your deductible or out-of-pocket limit.



Diagnostic Test

This chart explains what you will pay for a diagnostic test, depending on the type of provider you use. Under this plan, you will pay the least by getting care from a lab that is on a list of specified locations. If you receive services from a lab on this list, you would pay \$25 per visit, even if you have not met your deductible. If you use a lab that is not on the specified locations list but is still in-network, your cost depends on whether you have reached your deductible. If you have reached your deductible, you will pay 50% of the bill for the service. Your insurance will pay the other 50%. If you have not reached your deductible, you will pay 100% of the bill for the service until you reach your deductible. Then you would pay 50% coinsurance toward the remainder of the bill. Out-of-network providers are not covered at all on this plan.

If your healthcare provider wants you to get a test, ask which lab they are using and if it is in-network. If it's out-of-network, ask if they can refer you to an in-network lab instead, or call your insurance company to see if the lab test will be covered.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Preferred Network Provider (You will pay the rest)	Standard Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
Diagnostic Test	X-ray Blood work	Lab Services from a Specified Location: \$25 copay, deductible does not apply. All other: 50% coinsurance after deductible.		Not Covered	Please refer to our website for a list of Specified Reference Lab locations, or contact Member Services for additional information.
If you are pregnant	Office visits	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Not Covered	Differences in Network are limited to services provided by a Preferred provider.
	Childbirth / delivery professional services	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Not Covered	
	Childbirth / delivery facility services	50% Coinsurance after Deductible	60% Coinsurance after Deductible	Not Covered	

Coverage for Pregnant Women

With this plan, if you are pregnant, your insurance will only begin to cover office visits, childbirth/delivery professional services, and childbirth/delivery facility services after you have met your deductible. Once you have met your deductible, your insurance will pay 50% (for Preferred In-Network providers) or 40% (for Standard In-Network providers) of covered services. Your provider can give you a "Good Faith Estimate" of the cost of your expected services to get a better sense of what your coinsurance costs might look like.

For example, the individual deductible on this plan is \$7,500. If you have not paid toward your deductible at all and receive a bill for childbirth that is \$15,000, you will pay the deductible amount of \$7,500. This will complete your deductible. For the remaining \$7,500 of the bill, you will pay 50% (Preferred In-Network) or 60% (Standard In-Network), and your insurance will cover the rest.

Terms and Definitions

Preferred In-Network	This health insurance plan is “tiered,” which means there are two levels of “in-network” providers. “Preferred In-Network” is the highest tier, which means you will pay the least in cost-sharing.
Standard In-Network	“Standard In-Network” is the second tier for this health plan. Seeing providers in this tier will cost more than seeing providers in the “Preferred In-Network” tier, but your health insurance plan will still cover some of the bill.
Out-of-Network	This means that your health insurance company does not have an agreement with these providers and may not cover any of the cost. If you’re unsure whether a provider is in-network, it’s important to confirm with your health insurance company before getting care.
Deductible	This is the amount you will pay for covered services before your health insurance plan begins to pay some or all of the cost. This does not apply to pre-deductible coverage, such as preventive care.
Copayment (copay)	This is a fixed amount of money you will pay to see certain providers or receive specific services. This amount changes based on the service and provider tier.
Coinsurance after deductible	This is the percentage of the total bill that you are responsible for after you’ve met your deductible. If your plan documents say you have 50% coinsurance after your deductible, this means you will be responsible for half the cost of care once you have reached your deductible. If you have not reached your deductible yet, you will be responsible for 100% of the bill until you reach your deductible, and 50% of the remaining balance.
Deductible does not apply	This means you don’t need to meet your deductible; you only need to pay your copay. For example, if your plan says “\$25 copay, deductible does not apply”, you pay \$25 for the office visit, even if you have not yet met your deductible.
30 Day Retail	This is the amount you pay to get a 30-day supply of prescription drugs from a pharmacy you visit in person.
90 Day Mail Order	This is the amount you pay to get a 90-day supply of prescription drugs through the mail.