



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 in-network. Without Baseline Completion: \$5,000 individual/\$10,000 family deductible in-network.	Generally, you must pay all 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. Curative requires the completion of a Baseline Visit within 120 days of your effective date in the Curative Plan, to ensure you will pay the lowest cost (typically \$0) for your copays, deductible, and coinsurance. The Baseline Visit is a meeting with a Curative Clinician to onboard you to the health plan and understand your health goals. The Baseline visit must be scheduled and completed within 120 calendar days of your effective date in the Curative Plan. In your first year, for the first 120 calendar days your costs will automatically align with the amounts noted for Baseline Completion, if you use a network provider. Reference your benefit booklet for Baseline Visit requirements at renewal. If you do not complete the Baseline Visit within 120 days, the copays, deductibles, and coinsurance shown in this and the following tables for “Without Baseline Completion” will apply. You are not required to answer health questions regarding disability or genetic information or complete medical examinations during the Baseline Visit in order to qualify as completed.
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 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/ .

Important Questions	Answers	Why This Matters:
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services
What is the out-of-pocket limit for this plan ?	With Baseline Completion: For network providers \$0 individual / \$0 family Non-Preferred Brand Name & Generic drugs and Non-preferred Specialty Drugs \$7,500/ Individual & 15,000 family for in-network. Without Baseline Completion: Annual maximum out-of-pocket is \$7,500/ individual & \$15,000 / family for in-network.	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 ?	Copayments for certain services, premiums , balance-billing charges, health care this plan doesn't cover and out-of-network coinsurance.	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 does not include coverage for services provided by Out-of-Network providers , except in certain circumstances described in the Benefits Booklet.
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	\$0	\$25 copay /visit	Not covered	None
	Specialist visit	\$0	\$50 copay /visit	Not covered	None
	Preventive care/screening /immunization	\$0	\$0	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	\$0	20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$0	20% coinsurance	Not covered	Prior authorization is required. If you don't get prior authorization , benefits could be reduced by 50% of the allowed amount of the service.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at curative.com/drugs	Preferred drugs (includes certain Generic, Brand Name & Specialty drugs	\$0	\$50 copay /prescription	Not covered	Prior authorization may be required. If you don't get prior authorization , your drug may not be covered. *For network providers \$7,500 individual/ \$15,000 family.
	Non-preferred Brand Name & Generic drugs (annual max out-of-pocket)*	\$50 copay /prescription	\$100 copay /prescription	Not covered	
	Non-preferred Specialty drugs (annual max out-of-pocket)*	\$250 copay /prescription	25% coinsurance	Not covered	

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0	20% coinsurance	Not covered	Prior authorization is required. If you don't get prior authorization , benefits could be reduced by 50% of the allowed amount of the service.
	Physician/surgeon fees	\$0	20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	\$0	20% coinsurance	Not covered	Limited to services in the United States
	Emergency medical transportation	\$0	20% coinsurance	Not covered	Limited to services in the United States
	Urgent care	\$0	20% coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0	20% coinsurance	Not covered	Prior authorization is required. If you don't get prior authorization , benefits could be reduced by 50% of the allowed amount of the service.
	Physician/surgeon fees	\$0	20% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Intensive Outpatient & partial hospitalization	\$0	20% coinsurance	Not covered	Prior authorization may be required. If you don't get prior authorization , benefits could be reduced by 50% of the allowed amount of the service.
	Inpatient services	\$0	20% coinsurance	Not covered	Prior authorization is required. If you don't get prior authorization , benefits could be reduced by 50% of the allowed amount of the service.

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 are pregnant	Office visits	\$0	\$25 copay /visit (first visit only)	Not covered	None
	Childbirth/delivery professional services	\$0	20% coinsurance	Not covered	None
	Childbirth/delivery facility services	\$0	20% coinsurance	Not covered	Prior authorization is required. If you don't get prior authorization , benefits could be reduced by 50% of the allowed amount of the service.
	Home health care	\$0	20% coinsurance	Not covered	Prior authorization is required. If you don't get prior authorization , benefits could be reduced by 50% of the allowed amount of the service.
If you need help recovering or have other special health needs	Rehabilitation services	\$0	20% coinsurance	Not covered	Prior authorization is required. If you don't get prior authorization , benefits could be reduced by 50% of the allowed amount of the service.
	Skilled nursing care	\$0	20% coinsurance	Not covered	Prior authorization is required. If you don't get prior authorization , benefits could be reduced by 50% of the allowed amount of the service.
	Durable medical equipment	\$0	20% coinsurance	Not covered	Prior authorization required for equipment totaling over \$750, standard manual and electric breast pumps covered up to \$500.
	Hospice services	\$0	20% coinsurance	Not covered	Prior authorization is required. If you don't get prior authorization , benefits could be reduced by 50% of the allowed amount of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

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 .)		
• Care outside of the United States	• Long-term care	• Routine foot care
• Chiropractic	• Private-duty nursing	• Routine vision care
• Cosmetic surgery	• Routine dental care	• Weight loss programs
• Infertility Treatment		
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (20 visits / plan year)	• Bariatric Surgery (once per lifetime)	• Hearing Aids (limits apply. See Benefit Booklet)

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 COBRA – U.S. Department of Labor – (866) 444-3272; for Texas state continuation – Texas Department of Insurance – (800) 252-3439. 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 at (855) 428-7284.

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, kwijigo holne' (855)-428-7284.

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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 [plan's overall deductible](#) **\$5000**
- [Specialist coinsurance](#) **20%**
- [Hospital \(facility\) coinsurance](#) **20%**
- [Other coinsurance](#) **20%**

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	\$5000
Copayments (1st office visit)	\$25
Coinsurance (20% of \$7625)	\$1535
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$6560

Note: These numbers assume the patient has not completed their Baseline Visit. If you have completed your Baseline Visit, Deductible, and Coinsurance for each of these examples.

Managing Joe's Type 2 Diabetes

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

- The [plan's overall deductible](#) **\$5000**
- [Specialist copayment](#) **\$50**
- [Hospital \(facility\) coinsurance](#) **20%**
- [Other coinsurance](#) **20%**

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	\$5000
Copayments (4 office visits)	\$200
Coinsurance (20% of \$400)	\$80
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$5280

Mia's Simple Fracture

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

- The [plan's overall deductible](#) **\$5000**
- [Specialist coinsurance](#) **20%**
- [Hospital \(facility\) coinsurance](#) **20%**
- [Other coinsurance](#) **20%**

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	\$2800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2800

Note: These numbers assume the patient has not completed their Baseline Visit. If you have completed your Baseline Visit, you will pay \$0 for your Copays, Deductible, and Coinsurance for each of these examples.