SmartCare by ELAN

Elite Plan

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

Coverage Period: 08/01/2025-09/30/2026
Coverage for: Employee / Family | **Plan Type:** PPO
Limited Benefits

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 us at 1-855-565-0260, Monday to Friday from 8:00 am to 5:00 pm Eastern time. For 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 mySmartCarebyElan.com or call 1-855-565-0260, Monday to Friday from 8:00 am to 5:00 pm Eastern time to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers
Are there services covered before you meet your deductible?	Not applicable	There is no deductible on this plan. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductible for specific services?	No.	You don't have to meet deductibles for specific services
What is the out-of- pocket limit for this plan?	Not Applicable.	This plan does not have an **out-of-pocket limit** on your expenses.
What is not included in the out–of–pocket limit?	Not Applicable.	This plan does not have an **out-of-pocket limit** on your expenses.
Will you pay less if you use a network provider?	Yes. For a list of **in-network providers**, visit mySmartCarebyElan.com or call 1-855-565-0260, Monday to Friday from 8:00 am to 5:00 pm Eastern time.	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).
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

For more information about limitations and exceptions, see the plan document at mySmartCarebyElan.com.

- All copayment and coinsurance costs shown in this chart apply.

		What You Will Pay:		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you visit a health care provider's office or clinic	Primary care (PCP) visits to treat an injury or illness	Teladoc: $0 copay (unlimited). $30 copay first two (2) visits $70 copay visits 3 through 10.	Up to $70 per visit - by reimbursement	Ten (10) visits per plan year after completing the plan's waiting period. Maximum visits combined for in and out-of-network. Services are covered through the First Health Limited Benefit Plan Network. Member is responsible for any amounts payable in excess of the maximum benefit.
	Specialist visit	$50 copay first two (2) visits; $100 copay visits 3 through 10.	Up to $100 per visit - by reimbursement	Ten (10) visits per plan year after completing the plan's waiting period. Maximum visits combined for in and out-of- network. Services are covered through the First Health Limited Benefit Plan Network. Member is responsible for any amounts payable in excess of the maximum benefit.
	Preventive care/ screening / immunization	No charge	Covered by reimbursement to the member with 40% coinsurance	Covers preventive services as required by Federal Law. Preventive services are only covered in-network. Services are covered through the First Health Limited Benefit Plan Network. Confirm with your provider that the services being rendered are preventive in nature, otherwise, you will pay for services that are not preventive.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay for labs and $75 for x rays.	$50 copay for labs and $100 for x rays - by reimbursement	Up to $1,000 each, per plan yearafter completing the plan's waiting period. Maximum allowance combined for in and out of network. Services are covered through the First Health Limited Benefit Plan Network. Member is responsible for any amounts payable in excess of the maximum benefit.
	Imaging (CT/PET scans, MRIs)	$350 copay	Up to $500 - by reimbursement.	One (1) study per plan year after completing the plan's waiting period. Maximum limit combined for in and out of network. Services are covered through the First Health Limited Benefit Plan Network. Member is responsible for any amounts payable in excess of the maximum benefit.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at mySmartCarebyElan.com.	Generic drugs (Tier 1)	$0 for preventive and OTC's $10 for Formulary medications	Not Covered	Over the counter (OTC's) medications in ELAN's formulary covered with a $0 copay. Preventive medications include: Aspirin, Fluoride, Iron supplements, Folic acid, Smoking cessation. High blood pressure, Bowel preps, Primary prevention of breast cancer, Contraceptives The plan only covers additional generic medications for the following conditions: Asthma/COPD, Depression, Diabetes; Heart Disease and Stroke; Cholesterol Lowering; Obesity
	Preferred Brand drugs (Tier 2)	Not covered	Not Covered	
	Non-Preferred Brand drugs (Tier 3)	Not covered	Not Covered	
	Specialty drugs (Tier 4)	Not covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$500 copay.	Up to $1,000 copay - covered by reimbursement.	$10,000 per plan year after completing the plan's waiting period. Maximum allowance combined for facility and in-patient physician services for both, in and out of network. Member is responsible for any amounts payable in excess of the maximum benefit.
	Physician/surgeon fees	$500 copay.	Up to $1,000 copay - covered by reimbursement.	

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	Accident / Injury: $0 copay; Sickness: $350 copay.	Accident / Injury: $0 copay; Sickness: $350 copay	$3,000 per Plan year for Accident/Injury and another $3,000 for Sickness. Maximum allowance combined for in and out of network. Member is responsible for any amounts payable in excess of the maximum benefit.
	Emergency medical transportation	Ground: 20% COINS up to $250 per trip.	Up to $100 reimbursement per trip.	Ground ambulance covers one (1) trip per plan year after completing the plan's waiting period. Maximum Limit combined for in and out of network. Member is responsible for any amounts payable in excess of the maximum benefit.
	Urgent care	$50 copay per visit	Up to $75 reimbursement per visit.	Five (5) visits per plan year after completing the plan's waiting period. Maximum limit combined for in and out-of-network. Services are covered through the First Health Limited Benefit Plan Network. Member is responsible for any amounts payable in excess of the maximum benefit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay	Covered by reimbursement - $1,000 copay	$30,000 per plan year after completing the plan's waiting period. Maximum Allowance combined for facility and surgeons, for both in and out-of-network. Services are covered through the First Health Limited Benefit Plan Network. Member is responsible for any amounts payable in excess of the maximum benefit.
	Physician/surgeon fee	$500 copay	Covered by reimbursement - $1,000 copay	

		What You Will Pay:		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Teladoc Behavioral: $0 copay. $30 copay first two (2) visits; $70 copay visits 3 through 10	Up to $70 per visit - by reimbursement	PCP copay applies. Ten (10) visits per plan year after completing the plan's waiting period. Maximum limit combined for in and out of network. Services are covered, through the First Health Limited Benefit Plan Network. Member is responsible for any amounts payable in excess of the maximum benefit.
	Facility fee (e.g. hospital room)	$500 copay.	Covered by reimbursement - $1,000 copay	$30,000 per plan year after completing the plan's waiting period. Maximum Allowance combined for facility and inpatient physician services for both, in and out of network. Services are covered through the First Health Limited Benefit Plan Network. Member is responsible for any amounts payable in excess of the maximum benefit.
If you are pregnant	Office visits	$30 copay first two (2) visits; $70 copay visits 3 through 10	Up to $70 per visit reimbursement	Ten (10) visits per plan year after completing the plan's waiting period. Maximum limit combined for in and out-of-network. Services are covered through the First Health Limited Benefit Plan Network. Member is responsible for any amounts payable in excess of the maximum benefit.
	Childbirth/delivery professional services	$500 copay	Covered by reimbursement - $1,000 copay	Up to $30,000 per plan year after completing the plan's waiting period. Maximum Allowance combined for facility and inpatient physician services for both, in and out of network. Services are covered through the First Health Limited Benefit Plan Network. Member is responsible for any amounts payable in excess of the maximum benefit.
	Childbirth/delivery facility services	$500 copay	Covered by reimbursement - $1,000 copay	
If you need help recovering or have other special needs	Home health care	Not covered	Not covered	
	Rehabilitation services	$50 copay first two (2) visits; $100 copay visits 3 through 10	Up to $100 per visit - by reimbursement	Ten (10) visits per plan year after completing the plan's waiting period. Maximum limit combined for in and out of network. Services are covered through the First Health Limited Benefit Plan Network. Member is responsible for any amounts payable in excess of the maximum benefit.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special needs	Habilitation services	$50 copay first two (2) visits; $100 copay visits 3 through 10	Up to $100 per visit - by reimbursement	Ten (10) visits per plan year after completing the plan's waiting period. Maximum limit combined for in and out of network. Services are covered through the First Health Limited Benefit Plan Network. Member is responsible for any amounts payable in excess of the maximum benefit.
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	Not Covered	Not Covered	
	Hospice service	Not Covered	Not Covered	
If your child needs dental or eye care	Children's Eye exam	$0 Copay for dependent children up to and including 21 years old	Covered, 40% coinsurance, subject to reimbursement	You will need to pay the full amount and submit for reimbursement.
	Children's Glasses	Up to $100 allowance, afterwards a 97% coinsurance. Benefits available for dependent child(ren) up to and including 21 years of age.	Up to $100 allowance, afterwards a 97% coinsurance. Benefits available for dependent child(ren) up to and including 21 years of age.	You will need to pay the full amount and submit for reimbursement.
	Children's Dental check-up	$0 copay	Covered with 40% coinsurance and subject to reimbursement to the member.	You will need to pay the full amount and submit for reimbursement.

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 copayment	$100
Hospital (facility) coinsurance	$500
Other coinsurance/copay	$500

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	$1,685
Coinsurance	$0
What is not covered	
Limits or exclusions	$2,110
The total Peg would pay is	**$3,795**

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	$100
Hospital (facility) coinsurance	$500
Other coinsurance/copay	$500

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	$1,009
Coinsurance	$0
What is not covered	
Limits or exclusions	$790
The total Joe would pay is	**$1,799**

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

The plan's overall deductible	$0
Specialist copayment	$100
Hospital (facility) coinsurance	$500
Other coinsurance/copay	$500

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	$985
Coinsurance	$189
What is not covered	
Limits or exclusions	$373
The total Mia would pay is	**$1,547**

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.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" above.

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