





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 1-877-208-5952. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 1-877-208-5952 to request a copy. For assistance with claims and medical benefits contact Valenz Navcare Concierge Services at 1-877-208-5952. For **Preauthorization** or for **Case Management** contact Valenz at 1-877-208-2200.


Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$ 2,000 Individual / \$ 4,000 Family <b>Benefit Period: Calendar Year</b>	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> (Embedded).
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Prescription drugs</a> , <a href="#">Preventive care</a> and primary care services 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> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>Medical Maximum Out of Pocket:</b> \$5,450 Individual / \$10,400 Family <b>Prescription Drug Maximum Out of Pocket:</b> \$1,000 Individual / \$2,500 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 (Embedded). Prescription Drug maximum out of pocket does not cross accumulate with medical maximum out of pocket.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Rx Copays, <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">Preauthorization</a> for services, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the medical <a href="#">out-of-pocket limit</a> . Rx Copays accumulate separately towards the Prescription Drug Maximum <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	No. <b>This plan does not utilize a network for any services.</b> All services will be subject to Reference Based Pricing (RBP) based on 150% of the Medicare Reimbursement Rate.	This <a href="#">plan</a> does not use a provider <a href="#">network</a> . You may receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ).
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see a <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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	Office Setting: No Charge Facility Setting: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		Included are in office surgical procedures. Telemedicine with \$0 cost share via Health Wallet at <a href="http://www.thehealthwallet.com">www.thehealthwallet.com</a> or at 1-800-363-3725
	<a href="#">Specialist</a> visit to treat an injury or illness	Office Setting: No Charge Facility Setting: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		Included are in office surgical procedures.
	<a href="#">Preventive care/screening/immunization</a>	No Charge Claims paid at Reference Based Pricing of 150% of Medicare allowable		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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Office Setting: No Charge Facility Setting: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		None.
	Imaging (CT/PET scans, MRIs)	Office Setting: No Charge Facility Setting: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		Sleep Studies: All settings subject to Plan Deductible and Coinsurance. <a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed up to a maximum of \$500.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mypromotecare.com">www.mypromotecare.com</a> or call 1-888-478-3443	Generic drugs (Tier 1)	\$5 copay / prescription Retail \$10 copay/ prescription Mail Order	Not Covered	Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription). If a prescription is filled with a non-generic drug when a generic equivalent exists, member will be responsible for the cost difference between the non-generic drug and the generic equivalent.
	Preferred brand drugs (Tier 2)	\$40 copay / prescription Retail \$80 copay/ prescription Mail Order	Not Covered	
	Non-preferred brand drugs (Tier 3)	\$60 copay / prescription Retail \$120 copay/ prescription Mail Order	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 4)	Not Covered	Not Covered	

 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		<a href="#">Preauthorization</a> may be required for certain services. If required and not obtained benefit reduces to 50% of the allowed up to a maximum of \$500.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		None.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		None.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> / per visit Claims paid at Reference Based Pricing of 150% of Medicare allowable		None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		<a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed up to a maximum of \$500.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Setting: No Charge Facility Setting: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		None
	Inpatient services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		<a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed up to a maximum of \$500.

 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Office Setting: No Charge Facility Setting: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		<a href="#">Cost sharing</a> does not apply to certain <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). <a href="#">Preauthorization</a> is required for inpatient maternity stay if stay is beyond 48 hours for vaginal delivery or 96 hours for cesarean delivery. If <a href="#">Preauthorization</a> is required and not obtained benefit reduces to 50% of the allowed up to a maximum of \$500.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		Maximum 60 visits per benefit period. <a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed up to a maximum of \$500.
	<a href="#">Rehabilitation services</a>	Office Setting: No Charge Facility Setting: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		Maximum combined physical and occupational therapy visit limit of 20 visits per calendar year. 20 visit limit per calendar year for Chiropractic services. 20 visit limit for Speech Therapy per calendar year.
	<a href="#">Habilitation services</a>	Office Setting: No Charge Facility Setting: 10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		<a href="#">Preauthorization</a> is required for Speech Therapy or benefit reduces to 50% of the allowed up to a maximum of \$500.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		Maximum 60 visits per benefit period. <a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed up to a maximum of \$500.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		<a href="#">Preauthorization</a> is required for items over \$1,000 or benefit reduces to 50% of the allowed up to a maximum of \$500. PPACA mandated breast pumps are covered to a maximum of \$450 per pregnancy.

 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a> Claims paid at Reference Based Pricing of 150% of Medicare allowable		Maximum 180 days per lifetime. <a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed of the allowed up to a maximum of \$500.
If your child needs dental or eye care	Children's eye exam	Not Covered Except for ACA mandated services Any PPACA allowable services will be paid at Reference Based Pricing of 150% of Medicare allowable		One vision screening for children 3-5 years is covered as a preventive service Cost sharing does not apply for preventive services.
	Children's glasses	Not Covered Except for ACA mandated services Any PPACA allowable services will be paid at Reference Based Pricing of 150% of Medicare allowable		No coverage for glasses.
	Children's dental check-up	Not Covered Except for ACA mandated services Any PPACA allowable services will be paid at Reference Based Pricing of 150% of Medicare allowable		Dental caries fluoride application for infants and children up to 5 years are covered as preventive services. Cost sharing does not apply for preventive services.

#### 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>• Abortion - elective</li> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility Treatment</li> <li>• Long-term Care</li> <li>• Maternity Care for dependent daughters</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty Nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Respite care</li> <li>• Routine eye care (Adult)</li> <li>• Routine Foot Care</li> <li>• TMJ Treatment and Appliance</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.)**

- |                     |                             |                                      |
|---------------------|-----------------------------|--------------------------------------|
| • Chiropractic Care | • Home Health Care Services | • Rehabilitative Services (PT/OT/ST) |
|---------------------|-----------------------------|--------------------------------------|

**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 at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). For more information on your rights to continue coverage, contact the plan at 1-877-208-5952. 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: 1-877-208-5952.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual mark 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 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 1-877-208-5952

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-208-5952

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-208-5952

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-208-5952

*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>	\$2,000
■ <a href="#">Specialist copayment</a>	\$0
■ 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>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,670</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>	\$2,000
■ <a href="#">Specialist copayment</a>	\$0
■ 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>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$800
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,420</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>	\$2,000
■ <a href="#">Specialist copayment</a>	\$0
■ 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>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$2,000
Copayments	\$10
Coinsurance	\$30
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,040</b>