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 1-888-721-2128. 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 or call 1-888-773-6590 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?	N/A.	Not applicable as this plan has no deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	Eligible services are covered at 100%. Plan Participants are not responsible for any Cost sharing expenses.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	This plan has no out-of-pocket expenses because all eligible expenses are covered at 100%.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. This plan uses the Multi Plan PHCS Preventive Services Only Network. A list of network providers can be found at www.multiplan.com or call 1-800-922-4362.	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating 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	Not covered	Limited to a combined maximum (Primary care visits and other practitioner visits) of 6 visits per person per Calendar Year.
	Specialist visit	No Charge	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	Includes preventive health services specified in the health care reform law. No coverage non-network.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Maximum of 5 visits per person per Calendar Year
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	No coverage for imaging.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.magellanrx.com or call **1-800-443-5715**	Generic drugs	$5 copay (retail) $12.50 copay (mail-order)	Not covered	Covers up to a 30-day supply (retail prescription); 91-day supply (mail-order prescription). Limited to a combined maximum of 20 prescriptions for retail and for mail order drugs, per person per Calendar Year. *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	$40 copay (retail) $100 copay (mail-order)	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	None
	Specialty drugs	Not covered	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not covered	Maximum of 3 visits per calendar year.
	Physician/surgeon fees	No Charge	Not covered	
If you need immediate medical attention	Emergency room care	No Charge		Maximum of 5 visits (combined with Urgent Care visit maximum) per person per Calendar Year. Payment of out-of-network Covered Services will not exceed Usual and Customary charges.
	Emergency medical transportation	Not covered	Not covered	No coverage for emergency medical transportation.
	Urgent care	No Charge		Maximum of 5 visits (combined with Emergency room services visit maximum) per person per Calendar Year. Payment of out-of-network Covered Services will not exceed Usual and Customary charges.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not covered	Maximum of 3 visits per person per Calendar Year.
	Physician/surgeon fees	No Charge	Not covered	No coverage for physician/surgeon fees.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	No coverage for mental/behavioral health or substance abuse outpatient services.
	Inpatient services	Not covered	Not covered	No coverage for mental/behavioral health or substance abuse inpatient services.
If you are pregnant	Office visits	No Charge	Not covered	Limited to a combined maximum (Primary care visits and other practitioner visits) of 6 visits per person per Calendar Year
	Childbirth/delivery professional services	No Charge	Not covered	Maximum of 5 days (combined with all other Inpatient stays) per person per Calendar Year.
	Childbirth/delivery facility services	No Charge	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	No coverage for home health care.
	Rehabilitation services	Not covered	Not covered	No coverage for rehabilitation services.
	Habilitation services	Not covered	Not covered	No coverage for habilitative services.
	Skilled nursing care	Not covered	Not covered	No coverage for skilled nursing care.
	Durable medical equipment	Not covered	Not covered	No coverage for durable medical equipment.
	Hospice services	Not covered	Not covered	No coverage for hospice service.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Applied from birth through age 5.
	Children's glasses	Not covered	Not covered	No coverage for glasses
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up

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.)		
• Acupuncture • Bariatric surgery • Chiropractic care • Cosmetic surgery • Delivery and all inpatient services • Dental care (Adult) • Diagnostic test (x-ray, blood work) • Durable medical equipment • Emergency medical transportation • Facility fee (e.g., hospital room) • Glasses (Adult)	• Habilitative services • Hearing aids • Home health care • Hospice service • Imaging (CT / PET scans, MRIs) • Infertility treatment • Long-term care • Mental / Behavioral health services • Non-emergency care when traveling outside the U.S. • Other practitioner office visit	• Postnatal care • Private-duty nursing • Rehabilitation services • Routine eye care (Adult) – limitations may apply • Routine foot care • Skilled nursing care • Specialist visit • Substance Use Disorder services • Urgent care • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Emergency room services • Surgeon fees	• Physician Visits	• Lab and X-rays

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-888-773-6590. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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 the plan at 1-888-773-6590. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. "Additionally, a consumer assistance program can help you file your appeal Contact 888-614-5400. A list of states with Consumer Assistance Programs is available at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **No**

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 1-888-721-2128.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-721-2128.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-888-721-2128.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-721-2128.

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	$0.00
Specialist coinsurance	100%
Hospital (facility) coinsurance	100%
Other coinsurance	100%

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10,300
The total Peg would pay is	**$10,300**

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

The plan's overall deductible	$0.00
Specialist coinsurance	100%
Hospital (facility) coinsurance	100%
Other coinsurance	100%

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,239
The total Joe would pay is	**$7,239**

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

The plan's overall deductible	$0.00
Specialist coinsurance	100%
Hospital (facility) coinsurance	100%
Other coinsurance	100%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,925
The total Mia would pay is	**$1,925**