





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 1-888-773-6590. 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.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-888-773-6590 to request a copy.


| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| What is the overall <a href="#">deductible</a> ?                                | \$0 Individual / \$0 Family<br><b>Benefit Period: Plan Year</b>  | N/A.  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | N/A  | This plan has no deductible. See a list of covered preventive services 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="#">deductible</a> for specific services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$7,350 individual / \$14,700 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).  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <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 <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. This plan uses the <b>Multiplan PHCS Practitioner and Ancillary Services Network</b> . A list of network providers can be found at <a href="http://www.multiplan.com">www.multiplan.com</a> or call 1-877-952-7427. | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might 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> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| 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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>  | Primary care visit to treat an injury or illness       | \$25 <a href="#">copay</a> //per visit  | \$25 <a href="#">copay</a> //per visit             | Limit of 4 visits per Plan year.<br><b>Hospital Based services are excluded.</b><br>Telemedicine via Health Wallet with no charge or limitation on use at <a href="http://www.thehealthwallet.com">www.thehealthwallet.com</a> or call 1-888-995-2759. |
|  | <a href="#">Specialist</a> visit                       | \$50 <a href="#">copay</a> //per visit  | \$50 <a href="#">copay</a> //per visit             | Limit of 4 visits per Plan year.<br><b>Hospital Based services are excluded.</b><br>Telemedicine via Health Wallet with no charge or limitation on use at <a href="http://www.thehealthwallet.com">www.thehealthwallet.com</a> or call 1-888-995-2759. |
|  | <a href="#">Preventive care/screening/immunization</a> | No Charge   | No Charge  | Includes <a href="#">preventive</a> health services specified in the health care reform law.<br><b>Hospital Based services are excluded.</b>   |
| <b>If you have a test</b>  | <a href="#">Diagnostic test</a> (x-ray, blood work)    | \$50 <a href="#">copay</a> /per visit   | \$50 <a href="#">copay</a> /per visit              | Limit of 3 visits per Plan year. Combined limit radiology and laboratory services.<br><b>Hospital Based services are excluded.</b>   |
|  | Imaging (CT/PET scans, MRIs)                           | \$350 Co-pay/ per visit<br>(Subject to Referenced Based Pricing at 150% of Medicare allowed rate) |  | Limit of 2 visit per Plan year.<br><b>Hospital Based services are excluded.</b><br><a href="#">Preauthorization</a> is required or benefit will be reduced by 50%.   |
| <b>If you need drugs to treat your illness or condition</b><br>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  | \$0 for Preventive Medicine<br>\$10 <a href="#">copay</a>   | Not Covered  | Subject to formulary.<br>Retail: 0-30 day supply<br>Mail Order: 31-90 day supply   |
|  | Limited brand drugs                                    | Not Covered   | Not Covered  | Subject to formulary   |
|  | Non-preferred brand drugs                              | Not Covered   | Not Covered  | None   |
|  | <a href="#">Specialty drugs</a>                        | Not Covered   | Not Covered  | None   |

 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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | \$350 Co-pay/ per visit<br>(Subject to Referenced Based Pricing at 150% of Medicare allowed rate) |  | Limit of 1 Outpatient Surgery per Plan year.<br>Anesthesia Limited to 1 Outpatient anesthetic procedures per plan year included in Outpatient Facility Benefit.<br><a href="#">Preauthorization</a> is required or benefit will be reduced by 50%. |
|   | Physician/surgeon fees                           | No charge   | No charge  | Included in Outpatient Facility or Free-standing facility services and Surgery Copay   |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | Not Covered   |  | None.  |
|   | <a href="#">Emergency medical transportation</a> | Not Covered   |  | None.  |
|   | <a href="#">Urgent care</a>                      | \$50 <a href="#">copay</a> /per visit   | \$50 <a href="#">copay</a> /per visit              | Limited to 3 Urgent Care visits per Plan year.<br><b>Hospital Based services are excluded.</b>   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | Not Covered   |  | None.  |
|   | Physician/surgeon fees                           | Not Covered   | Not Covered  | None.  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Not Covered   | Not Covered  | None.  |
|   | Inpatient services                               | Not Covered   |  | None.  |
| If you are pregnant   | Office visits                                    | Not Covered   | Not Covered  | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , <a href="#">some prenatal testing</a> , <a href="#">screenings</a> , and <a href="#">laboratory services</a> .   |
|   | Childbirth/delivery professional services        | Not Covered   | Not Covered  |  |
|   | Childbirth/delivery facility services            | Not Covered   |  | None.  |

 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | Not Covered                                  | Not Covered  | None.  |
|  | <a href="#">Rehabilitation services</a>   | Not Covered                                  | Not Covered  | None.  |
|  | <a href="#">Habilitation services</a>     | Not Covered                                  | Not Covered  | None.  |
|  | <a href="#">Skilled nursing care</a>      | Not Covered                                  | Not Covered  | None.  |
|  | <a href="#">Durable medical equipment</a> | Not Covered                                  | Not Covered  | None.  |
|  | <a href="#">Hospice services</a>          | Not Covered                                  | Not Covered  | None.  |
| If your child needs dental or eye care                         | Children's eye exam                       | Not Covered                                  | Not Covered  | 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                                  | Not Covered  | No coverage for glasses  |
|  | Children's dental check-up                | Not Covered                                  | Not Covered  | 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 and Therapeutic</li> <li>• Acupuncture</li> <li>• Allergy testing except as required by ACA</li> <li>• Aquatic therapy</li> <li>• Bariatric surgery</li> <li>• Biofeedback</li> <li>• Chemotherapy</li> <li>• Childbirth/Delivery and postnatal care</li> </ul> | <ul style="list-style-type: none"> <li>• Emergency Medical Transportation</li> <li>• Glasses (Adult)</li> <li>• Habilitative services</li> <li>• Halfway house/home</li> <li>• Hearing aids</li> <li>• Home Health Care</li> <li>• Hospice services</li> <li>• Infertility treatment / services</li> </ul> | <ul style="list-style-type: none"> <li>• Nutritional Counseling diabetic</li> <li>• Nutritional Counseling non-diabetic</li> <li>• Primary Care Physician (PCP) Surgery</li> <li>• Private-duty nursing</li> <li>• Radiation Therapy</li> <li>• Rehabilitation services</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> </ul> |
|--|--|---|

|   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Cosmetic surgery (not related to Mastectomy)</li> <li>• Dental care (Adult and Child) other than ACA mandated</li> <li>• Dialysis therapy</li> <li>• Durable medical equipment</li> <li>• Genetic testing other than ACA mandated</li> <li>• Emergency Room Services</li> </ul> | <ul style="list-style-type: none"> <li>• Inpatient Hospitalization/surgery</li> <li>• Long-term care</li> <li>• Massage therapy</li> <li>• Maternity Care for Dependent Daughters</li> <li>• Maternity/Pregnancy Care except as required by ACA</li> <li>• Mental / Behavioral Health services</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Sex reassignment/change procedures and investigational studies.</li> <li>• Sexual dysfunction</li> <li>• Skilled nursing facilities</li> <li>• Substance/Chemical Abuse Health Services</li> <li>• TMJ Treatment and Appliances</li> <li>• Transplants and Transplant services</li> <li>• Vision Exam and Hardware</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.)**

- |                                       |                                  |               |
|---------------------------------------|----------------------------------|---------------|
| • Diagnostic test (x-ray, blood work) | • Imaging (CT / PET scans, MRIs) | • Urgent care |
|---------------------------------------|----------------------------------|---------------|

**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 1-888-773-6590. 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: 1-888-773-6590.

**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? 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 1-888-773-6590

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-773-6590

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-773-6590

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-773-6590

*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> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$25 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 100% |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,687</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                 |
|-----------------------------------|-----------------|
| Deductibles                       | \$0             |
| Copayments                        | \$631           |
| Coinsurance                       | \$0             |
| What isn't covered                |                 |
| Limits or exclusions              | \$11,131        |
| <b>The total Peg would pay is</b> | <b>\$11,762</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> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$25 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 100% |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,601</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$0            |
| Copayments                        | \$481          |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$4,013        |
| <b>The total Joe would pay is</b> | <b>\$4,494</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> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$25 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 100% |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$0            |
| Copayments                        | \$255          |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$2,341        |
| <b>The total Mia would pay is</b> | <b>\$2,596</b> |