





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.healthcare.gov/sbc-glossary 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 **Pre-Authorization** and **Case Management Services** contact Valenz Navcare at 1-877-208-5952.


Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0 Individual / \$0 Family Benefit Period: Plan Year	N/A.
Are there services covered before you meet your deductible ?	N/A	This plan has no deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
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 ?	\$7,350 individual / \$14,700 family	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. (Non-Embedded)
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, penalties for failure to obtain Preauthorization for services, and health care this plan doesn't cover.	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. This plan uses the Multiplan PHCS Practitioner and Ancillary Services Network . A list of network providers can be found at www.multiphan.com/phcspracanc or call 1-877-952-7427.	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 a 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 (You will pay the least)	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	\$25 copay /per visit	\$25 copay /per visit	Limit of 6 visits per Plan year. Hospital Based services are excluded. Telemedicine via Health Wallet with no charge or limitation on use at www.thehealthwallet.com or call 1-800-363-3725.
	Specialist visit	\$50 copay /per visit	\$50 copay /per visit	Limit of 6 visits per Plan year. Hospital Based services are excluded. Telemedicine via Health Wallet with no charge or limitation on use at www.thehealthwallet.com or call 1-800-363-3725.
	Preventive care/screening/immunization	No Charge	No Charge	Includes preventive health services specified in the health care reform law. Hospital Based services are excluded.
If you have a test	Diagnostic test (x-ray, blood work)	\$50 copay /per visit	\$50 copay /per visit	Limit of 3 visits per Plan year. Combined limit radiology and laboratory services. Hospital Based services are excluded.
	Imaging (CT/PET scans, MRIs)	\$350 Co-pay/ per visit (Subject to Referenced Based Pricing at 150% of Medicare allowed rate)		Limit of 1 visit per Plan year. Hospital Based services are excluded. Preauthorization is required or benefit will be reduced by 50%.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mypromotecare.com or call 1-888-478-3443	Generic drugs	\$0 for Preventive Medicine \$10 copay	Not Covered	Subject to formulary. Retail: 0-30 day supply 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
	Specialty drugs	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 (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)	\$350 Co-pay/ per visit (Subject to Referenced Based Pricing at 150% of Medicare allowed rate)		Limit of 1 Outpatient Surgery per Plan year. Anesthesia Limited to 1 Outpatient anesthetic procedures per plan year included in Outpatient Facility Benefit. Preauthorization 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	Emergency room care	\$350 Co-pay/ per visit (Subject to Referenced Based Pricing at 150% of Medicare allowed rate)		Limited to 1 Emergency Room visit per Plan year.
	Emergency medical transportation	\$250 Co-pay/ per visit (Subject to Referenced Based Pricing at 150% of Medicare allowed rate)		Limited to 1 Emergency Medical Transportation trip per Plan year. Ground ambulance only.
	Urgent care	\$50 copay /per visit	\$50 copay /per visit	Limited to 2 Urgent Care visits per Plan year. Hospital Based services are excluded.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$350 Co-pay/ per admission (Subject to Referenced Based Pricing at 150% of Medicare allowed rate)		Limited to 3 Inpatient days per Plan year. (Inpatient Maternity excluded) Preauthorization is required or benefit will be reduced by 50%.
	Physician/surgeon fees	No charge (included in Inpatient Hospitalization copay)	No charge (included in Inpatient Hospitalization copay)	Limited to 3 Physician visit days per plan year. Limited to 2 Inpatient Surgeries per plan year. Anesthesia services are limited to 2 Inpatient anesthetic procedures per plan year.

 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 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	Cost sharing does not apply for preventive services , some prenatal testing , screenings , and laboratory services .
	Childbirth/delivery professional services	Not Covered	Not Covered	
	Childbirth/delivery facility services	Not Covered		None.
If you need help recovering or have other special health needs	Home health care	\$25 copay / per visit	\$25 copay / per visit	Limited to 5 visits per Plan year Preauthorization is required or benefit will be reduced by 50%.
	Rehabilitation services	Not Covered	Not Covered	None
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Not Covered	Not Covered	None
	Durable medical equipment	Not Covered	Not Covered	None
	Hospice services	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](#).)

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|---|--|---|
| • Abortion – Elective and Therapeutic | • Glasses (Adult) | • Primary Care Physician (PCP) Surgery |
| • Acupuncture | • Habilitative services | • Private-duty nursing |
| • Allergy testing except as required by ACA | • Halfway house/home | • Radiation Therapy |
| • Aquatic therapy | • Hearing aids | • Rehabilitation services |
| • Bariatric surgery | • Hospice services | • Routine eye care (Adult) |
| • Biofeedback | • Infertility treatment / services | • Routine foot care |
| • Chemotherapy | • Long-term care | • Sex reassignment/change procedures and investigational studies. |
| • Childbirth/Deliver and postnatal care | • Massage therapy | • Sexual dysfunction |
| • Chiropractic care | • Maternity Care for Dependent Daughters | • Skilled nursing facilities |
| • Cosmetic surgery (not related to Mastectomy) | • Maternity/Pregnancy Care except as required by ACA | • Substance/Chemical Abuse Health Services |
| • Dental care (Adult and Child) other than ACA mandated | • Mental / Behavioral Health services | • TMJ Treatment and Appliances |
| • Dialysis therapy | • Non-emergency care when traveling outside the U.S. | • Transplants and Transplant services |
| • Durable medical equipment | • Nutritional Counseling diabetic | • Vision Exam and Hardware |
| • Genetic testing other than ACA mandated | • Nutritional Counseling non-diabetic | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---------------------------------------|--------------------------------------|----------------------------|
| • Diagnostic test (x-ray, blood work) | • Facility fee (e.g., hospital room) | • Inpatient Services |
| • Emergency medical transportation | • Home Health Care | • Physician / surgeon fees |
| • Emergency room services | • 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or 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 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? 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 1-877-208-5952

[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 plan's overall deductible	\$0
■ Specialist copayment	\$25
■ 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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$631
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$11,131
The total Peg would pay is	\$11,762

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	\$25
■ 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$481
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$4,013
The total Joe would pay is	\$4,494

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$25
■ 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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$855
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$612
The total Mia would pay is	\$1,467