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 1-646-357-9008. 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 1-646-357-9008 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	N/A
Are there services covered before you meet your deductible?	Yes. Preventive care and prescription drug coverage are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your 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?	Network providers: $5,000 individual / $10,000 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.
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.multiplan.com 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	$15 copay	Not Covered	Limit of 12 visits per Plan year. Not covered if provided at a hospital. Telemedicine covered at no charge with no limitations via Health Wallet at www.thehealthwallet.com or call 1-888-995-2759
	Specialist visit	$25 copay	Not Covered	Limit of 12 visits per Plan year. Not covered if provided at a hospital. Telemedicine covered at no charge with no limitations via Health Wallet at www.thehealthwallet.com or call 1-888-995-2759
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. No coverage non-network. Not covered if provided at a hospital.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay/per visit	Not Covered	Limit of 4 visits per Plan year. Not covered if services are provided at a hospital.
	Imaging (CT/PET scans, MRIs)	$350 Co-pay (Subject to Reference Based Pricing of 150% of Medicare allowed rate)		Limit of 3 visit per Plan year. Not covered if services provided at a hospital. Preauthorization is required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.omnipbm.com/engage or call **1-888-478-3443**	Generic drugs	20% copay	Not Covered	Subject to formulary
	Preferred brand drugs	20% copay	Not Covered	Subject to formulary
	Non-preferred brand drugs	Not Covered	Not Covered	None
	Specialty drugs	Not Covered	Not Covered	None

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 (Subject to Reference Based Pricing of 150% of Medicare allowed rate)		Limit 2 visit per Plan year. Preauthorization is required.
	Physician/surgeon fees	No charge	Not covered	Combined with inpatient and outpatient professional services. Limited to 4 days per Plan year. Preauthorization is required.
If you need immediate medical attention	Emergency room care	$350 Co-pay (Subject to Reference Based Pricing of 150% of Medicare allowed rate)		Limit 2 visit per Plan year.
	Emergency medical transportation	$250 Co-pay (Subject to Reference Based Pricing of 150% of Medicare allowed rate)		Limit 2 visit per Plan year. Ground ambulance only.
	Urgent care	$35 copay/per visit	Not Covered	Limited to 3 visits per Plan year. Not covered if provided at a hospital.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 Co-pay (Subject to Reference Based Pricing of 150% of Medicare allowed rate)		Limit 10 days per Plan year. (combined with Inpatient Maternity) Preauthorization is required.
	Physician/surgeon fees	No charge	Not covered	Combined with inpatient and outpatient professional services. Limited to 4 days per Plan year. Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/per visit	Not Covered	Limited to 10 visits per Plan year. Preventive services are covered for mental, behavioral health or substance abuse. Cost sharing does not apply for preventive services. Partial hospitalization is not covered.
	Inpatient services	$250 Co-pay (Subject to Reference Based Pricing of 150% of Medicare allowed rate)		Limited to 10 days per Plan year. Preauthorization is required.
If you are pregnant	Office visits	$350 copay	Not Covered	Childbirth/ delivery Professional Services Co-pay includes Maternity standard office visits.
	Childbirth/delivery professional services			

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)	
	Childbirth/delivery facility services	$350 Co-pay (Subject to Reference Based Pricing of 150% of Medicare allowed rate)		Limit 10 days per Plan year. (combined with Inpatient Hospital stays) Preauthorization is required for inpatient stay over 48 hours for a vaginal delivery or 96 hours for a cesarean section.
If you need help recovering or have other special health needs	Home health care	$25 copay/per visit	Not Covered	Limited to 20 visits per Plan year Preauthorization is required.
	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.)

- Bariatric Surgery
- Cosmetic Surgery
- Hearing Aids
- Long-Term Care
- Non-Emergency Care outside US
- Private Duty Nursing
- Routine Dental Care
- Routine Eye Care
- Routine Foot Care
- Weight Loss Programs
- Skilled Nursing
- Infertility Services
- Durable Medical Equipment
- Acupuncture
- Hospice Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Home Health • Office Visits	• Emergency Room • Lab/X-ray • Inpatient Services	• Behavioral Health • Telemedicine via Health Wallet at www.thehealthwallet.com or call 1-888-995-2759

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 1-646-357-9008. 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: 1-646-357-9008.

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? 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 1-646-357-9008.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-646-357-9008.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-646-357-9008.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-646-357-9008

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,320
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,380**

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,280
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,365
The total Joe would pay is	**$6,645**

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$875
Coinsurance	$0
What isn't covered	
Limits or exclusions	$252
The total Mia would pay is	**$1,127**

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