**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 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 Healthlink at 1-877-208-2200.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network providers: $0 Individual / $0 Family<br>Out-of-network providers: Not Covered<br>**Benefit Period**: **Calendar Year** | This plan has no deductible for network or out-of-network services.<br>See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | No. | 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?** | Network providers: $0 Individual / $0 Family<br>Out-of-network providers: Not Covered | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | Not Applicable | 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 **Multiplan PHCS Preventive Services Only Network**. A list of network providers can be found at www.multiplan.com or call 1-888-794-7427. | 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).<br>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 | Not covered | Not covered | No coverage for primary care visits to treat an injury or illness. Telemedicine with $0 cost share via Health Wallet at www.thehealthwallet.com or at 1-800-363-3725 |
| | Specialist visit | Not covered | Not covered | No coverage for specialists. |
| | Preventive care/screening/ immunization | No charge | Not covered | Includes preventive health services specified in the health care reform law. No coverage for Out of Network providers. Includes drug screening for job clearance and substance abuse. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Not covered | Not covered | No coverage for diagnostic testing. Except for job placement drug screenings. |
| | 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.mypromote care.com or call **1-888-478-3443** | Generic drugs | Not covered | Not covered | No Coverage for prescription drugs, except for PPACA approved preventive prescriptions. If you use a non-network pharmacy, you are responsible for the full amount. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply If you use a non-network pharmacy, you are responsible for any amount. |
| | Preferred brand drugs | Not covered | Not covered | |
| | Non-preferred brand drugs | Not covered | Not covered | |
| | Specialty drugs | Not covered | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not covered | Not covered | No coverage for facility fee. |
| | Physician/surgeon fees | Not covered | Not covered | No coverage for physician/surgeon fees. |
| **If you need immediate medical attention** | Emergency room care | Not covered | | No coverage for emergency room services. |
| | Emergency medical transportation | Not covered | Not covered | No coverage for emergency medical transportation. |
| | Urgent care | Not covered | Not covered | No coverage for urgent care. |

| 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) | Not covered | Not covered | No coverage for facility fee. |
| | Physician/surgeon fees | Not covered | 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 | Routine Prenatal: No charge<br>Postnatal: Not covered | Not covered | Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | Not covered | Not covered | No coverage for delivery or inpatient professional services. |
| | Childbirth/delivery facility services | Not covered | Not covered | No coverage for delivery or inpatient facility services. |
| **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 | Not Covered<br>Except for ACA mandated services | 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<br>Except for ACA mandated services | Not covered | No coverage for glasses. |

| 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) | |
| | Children's dental check-up | Not Covered Except for ACA mandated services | 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.)**

- 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
- Emergency room services
- 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
- Physician / surgeon fees
- Postnatal care
- Prescription drugs (except for PPACA approved preventive prescriptions)
- Private-duty nursing
- Rehabilitation services
- Routine eye care (Adult)
- Routine foot care
- Skilled nursing care
- Specialist visit
- Substance Use Disorder services
- Urgent care
- Vision Exam and Hardware
- Weight loss programs

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

**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, kwiijigo 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 | $0.00 |
| 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** | **$12,700** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $12,600 |
| **The total Peg would pay is** | **$12,600** |

### 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** | **$5,600** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $5,400 |
| **The total Joe would pay is** | **$5,400** |

### 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** | **$2,800** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $2,800 |
| **The total Mia would pay is** | **$2,800** |