



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.dol.gov/ebsa/healthreform](http://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 <a href="#">deductible</a> ?	\$0 Individual / \$0 Family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	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 <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 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 <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billing charges, 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 <a href="#">network provider</a> ?	Yes. This plan uses the Multiplan PHCS Practitioner and Ancillary Services Network. 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 the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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)	
<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 Co-pay per visit	\$25 Co-pay per visit	Limit of 3 visits per plan year. Not covered if services are provided at a hospital. Telemedicine covered at no charge with no limitations via Health Wallet at <a href="http://www.thehealthwallet.com">www.thehealthwallet.com</a> or call 1-888-995-2759
	<a href="#">Specialist</a> visit	\$50 Co-pay per visit	\$50 Co-pay per visit	Limit of 3 visits per plan year. Not covered if services are provided at a hospital.
	<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. No coverage non-network. Not covered if services are provided at a hospital.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 Co-pay per visit	\$50 Co-pay per visit	Limit of 2 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 1 visit per plan year. Not covered if services are provided at a hospital. Preauthorization is required
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.magellanrx.com">www.magellanrx.com</a> or call 1-800-443-5715	Generic drugs	\$0 For Preventive Medicine \$10 Co-pay per retail \$30 Co-pay mail order	Not covered	Subject to formulary. Retail: 0-30 day supply Mail Order: 31-90 day supply
	Preferred brand drugs	Not covered	Not covered	None
	Non-preferred brand drugs	Not covered	Not covered	None
	<a href="#">Specialty drugs</a>	Not covered	Not covered	None

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$350 Co-pay (Subject to Reference Based Pricing of 150% of Medicare allowed rate)		Limit of 1 visit per plan year. Anesthesia included in OP Facility Benefit Limited to 1 day. Preauthorization is required.
	Physician/surgeon fees	No charge	No charge	Included in Outpatient Hospital or Free Standing Facility Services and Surgery Copay.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Not covered		No coverage for emergency room services.
	<a href="#">Emergency medical transportation</a>	Not covered	Not covered	No coverage for emergency medical transportation.
	<a href="#">Urgent care</a>	\$50 Co-pay per visit	\$50 Co-pay per visit	Limit of 2 visits per plan year. Not covered if services are provided at a hospital.
<b>If you have a hospital stay</b>	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.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Not covered	Not covered	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	Not covered	Not covered	No coverage for mental/behavioral health or substance abuse inpatient services.
<b>If you are pregnant</b>	Office visits	Preventive Prenatal: No Charge Routine Prenatal: Not Covered Postnatal: Not Covered	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , some prenatal testing, screenings, and laboratory services.

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)	
	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.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not covered	Not covered	No coverage for home health care.
	<a href="#">Rehabilitation services</a>	Not covered	Not covered	No coverage for rehabilitation services.
	<a href="#">Habilitation services</a>	Not covered	Not covered	No coverage for habilitative services.
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	No coverage for skilled nursing care.
	<a href="#">Durable medical equipment</a>	Not covered	Not covered	No coverage for durable medical equipment.
	<a href="#">Hospice services</a>	Not covered	Not covered	No coverage for hospice service.
<b>If your child needs dental or eye care</b>	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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|---|--|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Chiropractic care</li><li>• Cosmetic surgery</li><li>• Delivery and all inpatient services</li><li>• Dental care (Adult)</li><li>• Durable medical equipment</li><li>• Emergency medical transportation</li><li>• Emergency room services</li></ul> | <ul style="list-style-type: none"><li>• Glasses (Adult)</li><li>• Habilitative services</li><li>• Hearing aids</li><li>• Home health care</li><li>• Hospice service</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Mental / Behavioral health services</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Postnatal care</li><li>• Private-duty nursing</li><li>• Rehabilitation services</li><li>• Routine eye care (Adult) – limitations may apply</li><li>• Routine foot care</li><li>• Skilled nursing care</li><li>• Substance Use Disorder services</li><li>• Weight loss programs</li></ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

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| <ul style="list-style-type: none"><li>• Urgent care</li></ul> | <ul style="list-style-type: none"><li>• Diagnostic test (x-ray, blood work)</li><li>• Telemedicine via Health Wallet at <a href="http://www.thehealthwallet.com">www.thehealthwallet.com</a> or call 1-888-995-2759</li></ul> | <ul style="list-style-type: none"><li>• Imaging (CT / PET scans, MRIs)</li></ul> |
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**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](http://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](http://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](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 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](http://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](http://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 1-646-357-9008.

[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, kwijigo holne' 1-646-357-9008.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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>	\$0.00
■ <a href="#">Specialist coinsurance</a>	100%
■ 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>\$12,840</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$940
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$11,418
<b>The total Peg would pay is</b>	<b>\$12,358</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>	\$0.00
■ <a href="#">Specialist coinsurance</a>	100%
■ 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>\$7,460</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,285
Coinsurance	\$
What isn't covered	
Limits or exclusions	\$5,494
<b>The total Joe would pay is</b>	<b>\$6,779</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>	\$0.00
■ <a href="#">Specialist coinsurance</a>	100%
■ 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>\$1,925</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,601
<b>The total Mia would pay is</b>	<b>\$1,801</b>