





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](http://www.healthcare.gov/sbc-glossary) or call 1-877-208-5952 to request a copy. **Valenz Navcare Concierge Services** at 1-877-208-5952. For **Pre-Authorization** and **Case Management Services** contact Valenz Navcare at 1-877-608-2200.


Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network providers</a> : \$0 Individual / \$0 Family <a href="#">Out-of-network providers</a> : \$0 Individual / \$0 Family <b>Benefit Period: Calendar Year</b>	This <a href="#">plan</a> has no <a href="#">deductible</a> for <a href="#">network</a> or <a href="#">out-of-network</a> services. 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. Prescription Drugs, Preventive Care, Emergency Care, and Urgent Care.	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> ?	<a href="#">Network providers</a> \$7,350 Individual / \$14,700 Family <a href="#">Out-of-network providers</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.multiphan.com/phcspracanc">www.multiphan.com/phcspracanc</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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <u><a href="#">provider's</a></u> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u><a href="#">copay</a></u> //per visit	\$25 <u><a href="#">copay</a></u> //per visit	Limit of 8 visits per Plan year. <b>Hospital Based services are excluded.</b> Telemedicine via Health Wallet with no charge or limitation on use at <u><a href="http://www.thehealthwallet.com">www.thehealthwallet.com</a></u> or call 1-800-363-3725.
	<u><a href="#">Specialist</a></u> visit	\$50 <u><a href="#">copay</a></u> //per visit	\$50 <u><a href="#">copay</a></u> //per visit	Limit of 8 visits per Plan year. <b>Hospital Based services are excluded.</b> Telemedicine via Health Wallet with no charge or limitation on use at <u><a href="http://www.thehealthwallet.com">www.thehealthwallet.com</a></u> or call 1-800-363-3725.
	<u><a href="#">Preventive care/screening/immunization</a></u>	No Charge	No Charge	Includes <u><a href="#">preventive</a></u> health services specified in the health care reform law. <b>Hospital Based services are excluded.</b>
<b>If you have a test</b>	<u><a href="#">Diagnostic test</a></u> (x-ray, blood work)	\$50 <u><a href="#">copay</a></u> /per visit	\$50 <u><a href="#">copay</a></u> /per visit	Limit of 3 visits per Plan year. Combined limit radiology and laboratory services. <b>Hospital Based services are excluded.</b>
	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. <b>Hospital Based services are excluded.</b> <u><a href="#">Preauthorization</a></u> is required or benefit will be reduced by 50%.
<b>If you need drugs to treat your illness or condition</b> More information about <u><a href="#">prescription drug coverage</a></u> is available at <u><a href="http://www.mypromotecare.com">www.mypromotecare.com</a></u> or call 1-888-478-3443	Generic drugs	\$0 for Preventive Medicine 20% <u><a href="#">copay</a></u>	Not Covered	Subject to formulary. Retail: 0-30 day supply Mail Order: 31-90 day supply
	Limited brand drugs	20% <u><a href="#">copay</a></u>	Not Covered	Subject to formulary
	Non-preferred brand drugs	Not Covered	Not Covered	None
	<u><a href="#">Specialty drugs</a></u>	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. <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>	\$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.
	<a href="#">Emergency medical transportation</a>	\$250 Co-pay/ per trip (Subject to Referenced Based Pricing at 150% of Medicare allowed rate)		Limited to 1 Emergency Medical Transportation trip per Plan year. <b>Ground ambulance only.</b>
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /per visit	\$50 <a href="#">copay</a> /per visit	Limited to 2 Urgent Care visits per Plan year. <b>Hospital Based services are excluded.</b>
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 5 Inpatient days per Plan year. (Inpatient Maternity excluded) <a href="#">Preauthorization</a> 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 5 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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay</a> /per visit	\$25 <a href="#">copay</a> /per visit	Limited to 8 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.

 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)	
	Inpatient services	\$250 Co-pay/ per admission (Subject to Referenced Based Pricing at 150% of Medicare allowed rate)		Limited to <b>5</b> days per Plan year. <a href="#">Preauthorization</a> is required or benefit will be reduced by 50%.
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.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$25 <a href="#">copay</a> / per visit	\$25 <a href="#">copay</a> / per visit	Limited to <b>10</b> visits per Plan year <a href="#">Preauthorization</a> is required or benefit will be reduced by 50%.
	<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](#).)

- |   |  |   |
|---|--|---|
| • Abortion  | • 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             | • TMJ Treatment and Appliances                                    |
| • Cosmetic surgery (not related to Mastectomy)          | • Genetic testing other than ACA mandated            | • Transplants and Transplant services                             |
| • Dental care (Adult and Child) other than ACA mandated | • Maternity/Pregnancy Care except as required by ACA | • Vision Exam and Hardware  |
| • Dialysis therapy                                      | • Non-emergency care when traveling outside the U.S. | • Weight loss programs  |
| • Durable medical equipment                             | • Skilled nursing facilities                         |   |
|   | • Sleep Management/Sleep Studies                     |   |

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

- |  |                                      |                            |
|--|--------------------------------------|----------------------------|
| • Chemical Abuse & Dependency Services | • Emergency room services            | • Inpatient Services       |
| • Diagnostic test (x-ray, blood work)  | • Facility fee (e.g., hospital room) | • Physician / surgeon fees |
| • Emergency medical transportation     | • 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 1-877-208-5952. 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](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: 1-877-208-5952.

### 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? 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 1-877-208-5952

[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): Dinekehgo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$50
■ 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>
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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	\$9,732
<b>The total Peg would pay is</b>	<b>\$10,363</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>	\$50
■ 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>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$557
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$3,938
<b>The total Joe would pay is</b>	<b>\$4,495</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>	\$50
■ 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>
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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
<b>The total Mia would pay is</b>	<b>\$1,467</b>