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, contact **Valenz Navcare Concierge** at **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 contact **Valenz Navcare Concierge** at **1-877-208-5952** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $0 Individual / $0 Family Out-of-network providers: $2,000 Individual / $13,200 **Benefit Period: Plan Year**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay (Embedded).
Are there services covered before you meet your deductible?	Yes. Prescription Drugs, Preventive care services, Emergency and Urgent care services 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: $2,000 Individual / $13,200 Family Out-of-network providers: Unlimited	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, the overall family out-of-pocket limit must be met (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 **Blue Cross Blue Shield PPO Network**. A list of network providers can be found at www.anthem.com or call 1-800-810-2583.	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	$20 copay / per visit	40% coinsurance after deductible	Telemedicine via Health Wallet with no charge or limitation on use at www.thehealthwallet.com or call 1-800-363-3725.
	Specialist visit	$40 copay / per visit	40% coinsurance after deductible	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.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay / per visit	40% coinsurance after deductible	None.
	Imaging (CT/PET scans, MRIs)	$400 copay/per visit	After Deductible and $400 copay/per visit (Plan pays up to 125% of Medicare Allowable Payment)	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.ingenio-rx.com or call **1-833-271-2374**	Generic drugs	$0 for Preventive PPACA Drugs Retail:$5 copay Mail Order: $15 copay	Not Covered	Subject to formulary. Retail: 0-30 day supply Mail Order: 31-90 day supply
	Limited brand drugs	Retail:$40 copay Mail Order:$120 copay	Not Covered	Subject to Formulary. If a prescription is filled with a non-generic drug when a generic equivalent exists, member will be responsible for the cost difference between the non-generic drug and the generic equivalent.
	Non-limited brand drugs	Retail: $80 copay Mail Order: $240 copay	Not Covered	
	Specialty drugs	Not Covered	Not Covered	Not Covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$400 copay/per visit	After Deductible and $400 Copay (Plan Pays up to 125% of Medicare Allowable Payment)	Preauthorization is required or benefit will be reduced by 50%.
	Physician/surgeon fees	No charge	No charge after Deductible (Plan pays up to 125% of	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)	
			Medicare Allowable Payment)	
If you need immediate medical attention	Emergency room care	$400 copay/per visit		None.
	Emergency medical transportation	$400 Co-pay/ per trip		**Ground Ambulance only.**
	Urgent care	$50 copay/per visit	40% coinsurance after deductible	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copay/per admission	After Deductible and $400 Copay (Plan Pays up to 125% of Medicare Allowable Payment)	Preauthorization is required or benefit will be reduced by 50%.
	Physician/surgeon fees	No charge (included in Inpatient Hospitalization copay)	No charge after Deductible (Plan pays up to 125% of Medicare Allowable Payment)	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/per visit	**Office Setting:** 40% Coinsurance after Deductible Plan pays up to 125% of Medicare Allowable Payment) **Facility Setting:** After Deductible is met (Plan pays up to 125% of Medicare Allowable Payment)	Preventive services are covered for mental, behavioral health or substance abuse. Cost sharing does not apply for preventive services. Methadone clinics & Halfway homes are excluded. ABA Therapy is covered. Partial hospitalization (PHP) and Intensive Outpatient Treatment is covered.
	Inpatient services	$400 copay/ per admission	After Deductible and $400 Copay (Plan Pays up to 125% of Medicare Allowable Payment)	Preauthorization is required or benefit will be reduced by 50%.

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 are pregnant	Office visits	$50 copay / per visit	40% coinsurance after deductible	Childbirth/ delivery Professional Services Co-pay includes Maternity standard office visits. Cost sharing does not apply for preventive services, some prenatal testing, screenings, and laboratory services.
	Childbirth/delivery professional services	No charge (included in Inpatient Hospitalization copay)	40% coinsurance after deductible	
	Childbirth/delivery facility services	$400 copay/ per day	After Deductible and $400 Copay (Plan Pays up to 125% of Medicare Allowable Payment)	Preauthorization is required for inpatient stay over 48 hours for a vaginal delivery or 96 hours for a cesarean section. If Preauthorization is required but is not obtained benefit will be reduced by 50%.
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 or benefit will be reduced by 50%.
	Rehabilitation services	$75 copay / per visit	Not Covered	Limited to 20 visits (combined Physical, Occupational, and Speech Therapy) per Plan year. Preauthorization is required or benefit reduces to 50% of the allowed. (Combined Rehabilitative/Habilitative)
	Habilitation services	$75 copay / per visit	Not Covered	Limited to 20 visits (combined Physical, Occupational, and Speech Therapy) per Plan year. Preauthorization is required or benefit reduces to 50% of the allowed. (Combined Rehabilitative/Habilitative)
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	$400 copay	40% coinsurance after deductible	Wig covered following Chemotherapy. Limited to 1 per benefit period $400 maximum benefit.

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)	
	Hospice services	**Facility:** $400 copay/per admission **Home Setting**: $400 copay 1st visit only	**Facility:** After Deductible and $400 Copay (Plan Pays up to 125% of Medicare Allowable Payment) **Home Setting**: After Deductible and $400 copay 1st visit only (Plan Pays up to 125% of Medicare Allowable Payment)	Limited to 30 days in a Facility per Lifetime. Unlimited days in Home setting. Preauthorization is required or benefit will be reduced by 50%.
If your child needs dental or eye care	Children's eye exam	Not covered 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	Not covered	No coverage for glasses.
	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
- Air/Water Emergency / non- Emergency transport.
- Alternative Medicine/Homeopathy
- Aquatic Therapy
- Bariatric Surgery
- Bereavement Counseling
- Biofeedback
- Cosmetic Surgery
- Cochlear Implants
- Custodial Care
- Dental Care (routine) Adult and Child except as required by ACA
- Foot Care (routine)
- Genetic testing beyond ACA Mandate
- Gene or Cellular therapy
- Half-way house
- Hearing Aids/Implantable Hearing devices
- Infertility Treatment/Services
- Long Term Care
- Maternity Care for Dependent Daughters
- Massage Therapy
- Methadone Clinics
- Non-Emergency Care when traveling outside the U.S.
- Non-Emergency Care in the ER setting
- Oral Surgery
- Private Duty Nursing
- Respite Care
- Sexual dysfunction
- Sleep Management Services/Sleep Studies
- Specialty Medication
- Sterilization reversals
- TMJ Treatment and Appliances
- Transgender Surgery
- Vasectomy
- Weight Loss Programs

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

- Home Health Services (25 visits per Plan Year)
- Hospice Services – Limited to 30 Facility days per Lifetime
- Rehabilitative Services – Limited to 20 visits per Plan Year – combined PT/OT/ST

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? **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): 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
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,160**

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	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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