



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.	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> ?	N/A.	Not applicable as this plan has no deductible.
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> ?	Eligible medical services are covered at 100%. Plan Participants are not responsible for any medical service <a href="#">Cost sharing</a> expense. Cost sharing does apply to Pharmacy Benefit.	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. This plan uses the Multi Plan PHCS PPO Network. A list of <a href="#">network providers</a> can be found at <a href="http://www.multiplan.com">www.multiplan.com</a> or call 1-800-922-4362.	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	No Charge	Not covered	Limited to a combined maximum (Primary care visits and other practitioner visits) of 4 visits per person per Calendar Year.
	<a href="#">Specialist</a> visit	No Charge	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	Includes <a href="#">preventive</a> health services specified in the health care reform law. No coverage non-network.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	Maximum of 3 visits per person per Calendar Year
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	No coverage for imaging.
<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	\$5 copay (retail) \$12.50 copay (mail-order)	Not covered	Covers up to a 30-day supply (retail prescription); 91-day supply (mail-order prescription). Limited to a combined maximum of 12 prescriptions for retail and for mail order drugs, per person per Calendar Year. *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	\$40 copay (retail) \$100 copay (mail-order)	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	None
	<a href="#">Specialty drugs</a>	Not covered	Not covered	None
<b>If you have outpatient surgery</b>	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.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No Charge		Maximum of 3 visits (combined with Urgent Care visit maximum) per person per Calendar Year. Payment of out-of-network Covered Services will not exceed Usual and Customary charges.
	<a href="#">Emergency medical transportation</a>	Not covered	Not covered	No coverage for emergency medical transportation.
	<a href="#">Urgent care</a>	No Charge		Maximum of 3 visits (combined with Emergency room services visit maximum) per person per Calendar Year. Payment of out-of-network Covered Services will not exceed Usual and Customary charges.

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 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	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.
<b>If you are pregnant</b>	Office visits	No Charge	Not covered	Limited to a combined maximum (Primary care visits and other practitioner visits) of 4 visits per person per Calendar Year
	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	No Charge	Not covered	Applied from birth through age 5.
	Children's glasses	Not covered	Not covered	No coverage for glasses
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<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>• Diagnostic test (x-ray, blood work)</li><li>• Durable medical equipment</li><li>• Emergency medical transportation</li><li>• Facility fee (e.g., hospital room)</li><li>• Glasses (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Habilitative services</li><li>• Hearing aids</li><li>• Home health care</li><li>• Hospice service</li><li>• Imaging (CT / PET scans, MRIs)</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Mental / Behavioral health services</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Other practitioner office visit</li><li>• Surgeon fees</li></ul>	<ul style="list-style-type: none"><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>• Specialist visit</li><li>• Substance Use Disorder services</li><li>• Urgent care</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Emergency room services</li></ul>	<ul style="list-style-type: none"><li>• Physician Visits</li></ul>	<ul style="list-style-type: none"><li>• Lab and X-rays</li></ul>

**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 1-888-773-6590. 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: 1-888-773-6590.

**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 1-888-773-6590.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-773-6590.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-773-6590.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-773-6590.

*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>	\$0.00
■ <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>\$12,687</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$9
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$10,018
<b>The total Peg would pay is</b>	<b>\$10,027</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>\$5,601</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$480
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,287
<b>The total Joe would pay is</b>	<b>\$1,767</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>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$2,096
<b>The total Mia would pay is</b>	<b>\$2,096</b>