



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. For assistance with claims and medical benefits contact **Valenz Navcare Concierge Services** at 1-877-208-5952. For **Pre-Authorization** and **Case Management Services** contact Valenz Navcare at 1-877-208-5952.

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> : \$500 individual / \$1,000 family <b>Benefit Period: Plan Year</b>	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before the plan begins to pay (Non-Embedded).
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> 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> ?	<b>In Network:</b> \$2,000 Individual / \$13,200 Family <b>Out of Network:</b> Unlimited	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> , the overall family <a href="#">out-of-pocket limit</a> must be met (Non-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 <a href="#">network providers</a> can be found at <a href="http://www.multiplan.com/phcspracanc">www.multiplan.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)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> / per visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<b>Hospital Based services are excluded.</b> Telemedicine via Health Wallet with no charge or limitation on use at <a href="http://www.thehealthwallet.com">www.thehealthwallet.com</a> or call 1-800-363-3725.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> / per visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<b>Hospital Based services are excluded.</b> Telemedicine via Health Wallet with no charge or limitation on use at <a href="http://www.thehealthwallet.com">www.thehealthwallet.com</a> or call 1-800-363-3725.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	60% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Includes <a href="#">preventive</a> health services specified in the health care reform law. <b>Hospital Based services are excluded.</b>
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 <a href="#">copay</a> / per visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<b>Hospital Based services are excluded.</b>
	Imaging (CT/PET scans, MRIs)	\$400 <a href="#">copay</a> /per visit (Plan pays up to 150% of Medicare Allowable Payment)		<a href="#">Preauthorization</a> is required or benefit will be reduced by 50%.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mypromotecare.com">www.mypromotecare.com</a> or call 1-888-478-3443	Generic drugs	\$0 for Preventive Medicine \$10 <a href="#">copay</a> – 30 day supply \$30 <a href="#">copay</a> – 90 day supply	Not Covered	Subject to formulary. Retail: 0-30 day supply Mail Order: 31-90 day supply
	Limited brand drugs	\$40 <a href="#">copay</a> – 30 day supply \$120 <a href="#">copay</a> – 90 day supply	Not Covered	Subject to formulary.
	Non-limited brand drugs	\$80 <a href="#">copay</a> – 30 day supply \$240 <a href="#">copay</a> – 90 day supply	Not Covered	Subject to formulary.
	<a href="#">Specialty drugs</a>	25% <a href="#">copay</a>	Not Covered	Subject to formulary.



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 have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$400 <a href="#">copay</a> /per visit (Plan pays up to 150% of Medicare Allowable Payment)		<a href="#">Preauthorization</a> is required or benefit will be reduced by 50%.
	Physician/surgeon fees	No charge	No charge after Deductible (Plan pays up to 150% of Medicare Allowable Payment)	None.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$400 <a href="#">copay</a> /per visit (Plan pays up to 150% of Medicare Allowable Payment)		None.
	<a href="#">Emergency medical transportation</a>	\$400 Co-pay/ per trip (Plan pays up to 150% of Medicare Allowable Payment)		<b>Ground Ambulance only.</b>
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /per visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<b>Hospital Based services are excluded.</b>
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$400 <a href="#">copay</a> /per admission (Plan pays up to 150% of Medicare Allowable Payment)		<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 after Deductible (Plan pays up to 150% of Medicare Allowable Payment)	None.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copay</a> /per visit	Deductible must be met AND a \$25 Copay/per visit (Plan pays up to 150% 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. Partial hospitalization is not covered.
	Inpatient services	\$250 <a href="#">copay</a> / per day (Plan pays up to 150% of Medicare Allowable Payment)		<a href="#">Preauthorization</a> 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 <a href="#">copay</a> / per visit	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Childbirth/ delivery Professional Services Co-pay includes Maternity standard office visits. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services, some prenatal testing, screenings, and laboratory services</a> . <a href="#">Preauthorization</a> is required for inpatient stay over 48 hours for a vaginal delivery or 96 hours for a cesarean section. If <a href="#">Preauthorization</a> is required but is not obtained benefit will be reduced by 50%.
	Childbirth/delivery professional services	No charge (included in Inpatient Hospitalization copay)	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	\$400 <a href="#">copay</a> /per admission (Plan pays up to 150% of Medicare Allowable Payment)		
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$25 <a href="#">copay</a> / per visit	Deductible must be met AND a \$25 Copay/per visit (Plan pays up to 150% of Medicare Allowable Payment)	Limited to 25 visits per Calendar Year. <a href="#">Preauthorization</a> is required or benefit will be reduced by 50%.
	<a href="#">Rehabilitation services</a>	\$75 <a href="#">copay</a> / per visit	Deductible must be met AND a \$75 Copay/per visit (Plan pays up to 150% of Medicare Allowable Payment)	Limited to 20 visits (combined Physical, Occupational, and Speech Therapy) per Calendar year. <a href="#">Preauthorization</a> is required for Speech Therapy or benefit reduces to 50% of the allowed.
	<a href="#">Habilitation services</a>	\$75 <a href="#">copay</a> / per visit	Deductible must be met AND a \$75 Copay/per visit (Plan pays up to 150% of Medicare Allowable Payment)	
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	None
	<a href="#">Durable medical equipment</a>	\$400 <a href="#">copay</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Hospice services</a>	\$400 <a href="#">copay</a> /per admission (Plan pays up to 150% of Medicare Allowable Payment)		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)	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered Except for ACA mandated	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 Except for ACA mandated	Not covered	No coverage for glasses
	Children's dental check-up	Not covered Except for ACA mandated	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](#).)**

- |                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• ABA (Applied Behavioral Analysis) Therapy</li> <li>• Abortion- elective</li> <li>• Acupuncture</li> <li>• Alternative Medicine/Homeopathy</li> <li>• Applied Behavior Analysis(ABA Therapy)</li> <li>• Bariatric Surgery</li> <li>• Bereavement Counseling</li> <li>• Biofeedback</li> <li>• Chiropractic Care</li> <li>• Cosmetic Surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Dental Care (routine) Adult and Child except as required by ACA</li> <li>• Foot Care (routine)</li> <li>• Half-way house</li> <li>• Hearing Aids/Implantable Hearing devices</li> <li>• Infertility Treatment/Services</li> <li>• Long Term Care</li> <li>• Maternity Care for Dependent Daughters</li> <li>• Massage Therapy</li> <li>• Methadone Clinics</li> </ul> | <ul style="list-style-type: none"> <li>• Non-Emergency Care when traveling outside the U.S.</li> <li>• Non-Emergency Care in the ER setting</li> <li>• Oral Surgery</li> <li>• Primary Care Physician Surgery</li> <li>• Private Duty Nursing</li> <li>• Respite Care</li> <li>• Sleep Management Services/Sleep Studies</li> <li>• TMJ Treatment and Appliances</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 [plan](#) document.)**

- |                                                      |                                                       |                           |
|------------------------------------------------------|-------------------------------------------------------|---------------------------|
| • Home Health Services (25 visits per Calendar Year) | • Hospice Services – Limited to 180 days per Lifetime | • Rehabilitative Services |
|------------------------------------------------------|-------------------------------------------------------|---------------------------|

**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 1-877-208-5952

[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>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

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

Cost Sharing	
Deductibles	\$0
Copayments	\$1,081
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$61
<b>The total Peg would pay is</b>	<b>\$1,142</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>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

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

Cost Sharing	
Deductibles	\$0
Copayments	\$1,807
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$22
<b>The total Joe would pay is</b>	<b>\$1,829</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>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

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

Cost Sharing	
Deductibles	\$0
Copayments	\$1,542
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,542</b>