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, please call 1-844-899-6612. 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 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall **deductible**?	$0 individual / $0 family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your **deductible**?	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other **deductibles** for specific services?	No.	You don't have to meet deductibles for specific services.
What is the **out-of-pocket limit** for this **plan**?	$5,000 individual / $10,000 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 **out-of-pocket limit**?	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 **network provider**?	Yes. See www.multiplan.com/phcspracanc or call 1-877-952-7427 for a list of network providers.	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 the 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	$15 copay	$15 copay	Limited to 10 visits per plan year.
	Specialist visit	$25 copay	$25 copay	Limited to 10 visits per plan year.
	Preventive care/screening/ immunization	$0 copay	$0 copay	Not covered if provided at a hospital. Plan pays 100% of covered preventive and wellness services. You may have to pay for services that aren't preventive. Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay	$50 copay	Out-Patient Services: Not covered if services are provided at a hospital. Combined limit of 3 visits per plan year for Laboratory Services and Radiology.
	Imaging (CT/PET scans, MRIs)	$350 copay (Subject to Reference Based Pricing)	$350 copay (Subject to Reference Based Pricing)	Out-Patient Services: Not covered if services are provided at a hospital. Limited to 2 per plan year. Preauthorization is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling 1-844-899-6612.	Generic drugs	20% coinsurance	Not Covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order prescription. Subject to formulary. $0 copay for preventive generic drugs.
	Preferred brand drugs	20% coinsurance	Not covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order prescription. Subject to formulary
	Non-preferred brand drugs	Not covered	Not covered	Not covered
	Specialty drugs	Not covered	Not covered	Not covered

* For more information about limitations and exceptions, see the plan or policy document.

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 copay (Subject to Reference Based Pricing)	$350 copay (Subject to Reference Based Pricing)	Limited to 2 visits per plan year. Preauthorization is required.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$350 copay (Subject to Reference Based Pricing)	$350 copay (Subject to Reference Based Pricing)	Limited to 1 visit per plan year. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate.
	Emergency medical transportation	$250 copay (Subject to Reference Based Pricing)	$250 copay (Subject to Reference Based Pricing)	By land only. Limited to 1 transport per plan year.
	Urgent care	$35 copay	$35 copay	Not covered if provided at a hospital. Limited to 3 visits per plan year.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 copay per admission (Subject to Reference Based Pricing)	$350 copay per admission (Subject to Reference Based Pricing)	Limited to 7 days per plan year. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate. Preauthorization is required.
	Physician/surgeon fees	Included in Inpatient Hospitalization copay	Included in Inpatient Hospitalization copay	Limited to visits up to 7 days per plan year.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/specialist visit $25 copay/other outpatient services	$25 copay/specialist visit $25 copay/other outpatient services	Not covered if provided at a hospital. Limited to 10 visits per plan year. Preventive services are covered formental, behavioral health or substance abuse. Cost sharing does not apply for preventive services.
	Inpatient services	$250 copay per day (Subject to Reference Based Pricing)	$250 copay per day (Subject to Reference Based Pricing)	Limited to 7 days per plan year. Preauthorization is required.
If you are pregnant	Office visits	Included in Professional Services copay	Included in Professional Services copay	See Professional Services limitations.
	Childbirth/delivery professional services	$350 copay	$350 copay	Professional Services only, including standard office visits.
	Childbirth/delivery facility services	$350 copay per admission (Subject to Reference Based Pricing)	$350 copay per admission (Subject to Reference Based Pricing)	Considered an Inpatient Hospital Stay.

* For more information about limitations and exceptions, see the plan or policy document.

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 need help recovering or have other special health needs	Home health care	$25 copay	$25 copay	Limited to 15 visits per plan year. Preauthorization is required.
	Rehabilitation services	$25 copay	$25 copay	Limit of 5 Rehabilitation visits and 5 Habilitation visits per plan year.
	Habilitation services	$25 copay	$25 copay	
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered	Not covered
	Hospice services	Not covered	Not covered	Not covered
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	Not covered
	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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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: 1-844-899-6612.

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? **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 1-844-899-6612.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-899-6612.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-899-6612.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-899-6612.

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

* For more information about limitations and exceptions, see the plan or policy document.

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 [copay]** **$25**
- **Hospital (facility) [copay]** **$350**
- **Other [*cost sharing*]** **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 **$17,005**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$5,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$96
The total Peg would pay is	**$3,790**

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 [copay]** **$25**
- **Hospital (facility) [copay]** **$350**
- **Other [*cost sharing*]** **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 **$8,017**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$920
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,052
The total Joe would pay is	**$7,102**

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

- **The plan's overall deductible** **$0**
- **Specialist [copay]** **$25**
- **Hospital (facility) [copay]** **$350**
- **Other [*cost sharing*]** **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 **$2,520**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$
Copayments	$1,22
Coinsurance	$
What isn't covered	
Limits or exclusions	$81
The total Mia would pay is	**$2,11**

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