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 or call 1-888-773-6590 to request a copy. For assistance with claims and medical benefits contact Empire Health Valenz Navcare Concierge Services at 1-877-208-5952. For **Case Management Services** and **Preauthorization** contact Valenz Navcare at 1-877-208-5952.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $0 Individual / $0 Family Out-of-network providers: Not Covered **Benefit Period:** Calendar Year	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	N/A.	Not applicable as this plan has no deductible.
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: Individual: Unlimited Family: Unlimited Out-of-network providers: Not Covered	This plan does not have an out-of-pocket limit on your expenses.
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.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. This plan uses the **Multiplan PHCS Practitioner and Ancillary Services Only Network.** A list of network providers can be found at www.multiplan.com/phcspracanc or call 1-877-952-7427.	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.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Co-pay per visit	Not covered	Limit of 3 visits per calendar year. Telemedicine covered at no charge with no limitations via 1800MD at 1-800-591-2076 or www.thehealthwallet.com
	Specialist visit	$50 Co-pay per visit	Not covered	Limit of 3 visits per calendar year. Telemedicine covered at no charge with no limitations via 1800MD at 1-800-591-2076 or www.thehealthwallet.com
	Preventive care/screening/ immunization	No charge	Not covered	Includes preventive health services specified in the health care reform law. No coverage non-network.
If you have a test	Diagnostic test (x-ray, blood work)	$50 Co-pay per visit	Not covered	Limit of 2 visits per calendar year.
	Imaging (CT/PET scans, MRIs)	$350 Co-pay	Not covered	Limit of 1 visit per calendar year.
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	$10 Co-pay per retail prescription up to $150	Not covered	$600 Annual Maximum for Generic Drugs
	Preferred brand drugs	Not covered	Not covered	None
	Non-preferred brand drugs	Not covered	Not covered	None
	Specialty drugs	Not covered	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 Co-pay	Not covered	Preauthorization required. Limit of 1 visit per calendar year. Anesthesia included in OP Facility Benefit Limited to 1 day.
	Physician/surgeon fees	No Charge	Not covered	Limited to 1 OP surgery per calendar year

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)	
If you need immediate medical attention	Emergency room care	Not covered		No coverage for emergency room services.
	Emergency medical transportation	Not covered	Not covered	No coverage for emergency medical transportation.
	Urgent care	$50 Co-pay per visit	Not covered	Limit of 2 visits per calendar year. Telemedicine covered at no charge with no limitations via 1800MD at 1-800-591-2076 or www.thehealthwallet.com
If you have a hospital stay	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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	No coverage for mental/behavioral health or substance abuse outpatient services. Mental/Behavioral Health Telemedicine covered at no charge with no limitations via 1800MD at: 1-800-591-2076.
	Inpatient services	Not covered	Not covered	No coverage for mental/behavioral health or substance abuse inpatient services.
If you are pregnant	Office visits	Routine Prenatal: No charge Postnatal: Not covered	Not covered	Cost sharing does not apply for preventive services.
	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.
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	No coverage for home health care.
	Rehabilitation services	Not covered	Not covered	No coverage for rehabilitation services.
	Habilitation services	Not covered	Not covered	No coverage for habilitative services.
	Skilled nursing care	Not covered	Not covered	No coverage for skilled nursing care.
	Durable medical equipment	Not covered	Not covered	No coverage for durable medical equipment.
	Hospice services	Not covered	Not covered	No coverage for hospice service.

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)	
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 Except for ACA mandated services	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.)**

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Delivery and all inpatient services
- Dental care (Adult)
- Durable medical equipment
- Emergency medical transportation
- Emergency room services
- Glasses (Adult)
- Habilitative services
- Hearing aids
- Home health care
- Hospice service
- Infertility treatment
- In Patient Facility fee (e.g., hospital room)
- In Patient Physician / surgeon fees and Postnatal care
- Long-term care
- Mental / Behavioral health services
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Rehabilitation services
- Routine eye care (Adult) – limitations may apply
- Routine foot care
- Skilled nursing care
- Substance Use Disorder services
- Weight loss programs

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

- Diagnostic test (x-ray, blood work)
- 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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? **No**.
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, kwiijigo 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 plan's overall deductible	$0.00
Specialist coinsurance	100%
Hospital (facility) coinsurance	100%
Other coinsurance	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)*

Total Example Cost	**$12,687**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$111
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,284
The total Peg would pay is	**$12,395**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0.00
Specialist coinsurance	100%
Hospital (facility) coinsurance	100%
Other coinsurance	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)*

Total Example Cost	**$5,601**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$359
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,399
The total Joe would pay is	**$4,758**

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

The plan's overall deductible	$0.00
Specialist coinsurance	100%
Hospital (facility) coinsurance	100%
Other coinsurance	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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,341
The total Mia would pay is	**$2,521**