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 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 https://www.healthcare.gov/sbc-glossary or call 1-866-738-0386 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	You don't have to meet a deductible with this plan. This plan covers certain preventive services without cost-sharing. 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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.multiplan.com or call 1-800-922-4362 for a list of network providers in the PHCS network.	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
		In-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	Not covered	Not covered	No coverage for primary care visit to treat an injury or illness.
	Specialist visit	0% of Covered Expenses	Not covered	No coverage other than preventive services as listed with a rating of A or B from the U.S. Preventive Services Task Force; certain immunizations and certain Women's and Children's Preventive Services.
	Preventive care/screening/ immunization	0% of Covered Expenses	Not covered	No coverage other than preventive services as listed with a rating of A or B from the U.S. Preventive Services Task Force; certain immunizations and certain Women's and Children's Preventive Services. You have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% of Covered Expenses	Not covered	No coverage other than preventive services as listed with a rating of A or B from the U.S. Preventive Services Task Force; certain immunizations and certain Women's and Children's Preventive Services.
	Imaging(CAT/PETscans, MRIs)	Not covered	Not covered	No coverage for imaging (CAT/PET scans, MRIs)
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at[https://memberaccess.procare.com]	Generic drugs	0% of Covered Expenses	Not covered	Coverage only provided for generic prescription female contraceptives and preventive drugs as listed with a rating of A or B from the U.S. Preventive Services Task Force when prescribed.
	Preferred brand drugs	0% of Covered Expenses	Not covered	
	Non-preferred brand drugs	0% of Covered Expenses	Not covered	
	Specialty drugs	Not covered	Not covered	Specialty drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Facility fee (e.g., ambulatory surgery center) not covered.
	Physician/surgeon fees	0% of Covered Expenses	Not covered	No coverage other than preventive services as listed with a rating of A or B from the U.S. Preventive Services Task Force; certain immunizations and certain Women's and

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
				Children's Preventive Services.
If you need immediate medical attention	Emergency room care	Not covered	Not covered	Emergency room care, Emergency medical transportation, and Urgent care not covered.
	Emergency medical transportation	Not covered	Not covered	
	Urgent care	Not covered	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	Facility fee (e.g., hospital room) and Physician/surgeon fees are not covered
	Physician/surgeon fees	Not covered	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% of Covered Expenses	Not covered	No coverage other than preventive services as listed with a rating of A or B from the U.S. Preventive Services Task Force; certain immunizations and certain Women's and Children's Preventive Services.
	Inpatient services	Not covered	Not covered	Inpatient services for mental health, behavioral health, or substance abuse services not covered.
If you are pregnant	Office visits	0% of Covered Expenses	Not covered	No coverage other than preventive services as listed with a rating of A or B from the U.S. Preventive Services Task Force; certain immunizations and certain Women's and Children's Preventive Services.
	Childbirth/delivery professional services	Not covered	Not covered	Childbirth/delivery professional services and childbirth/delivery facility services not covered.
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	Home health care, Rehabilitation services, Habilitation services, Skilled nursing care, Durable medical equipment, and Hospice services not covered.
	Rehabilitation services	Not covered	Not covered	
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Not covered	Not covered	
	Durable medical equipment	Not covered	Not covered	
	Hospice services	Not covered	Not covered	
If your child needs dental or eye care	Children's eye exam	0% of Covered Expenses	Not covered	Certain preventive services for vision screenings only.
	Children's glasses	Not covered	Not covered	Glasses not covered.
	Children's dental check-up	0% of Covered Expenses	Not covered	Certain preventive services covered for children only.

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 (Adult)
- 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.)

- No other covered 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: The Employer at 1-618-233-6754 , the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.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: Bay Bridge Administrators, PO Box 161690, Austin, TX 78716, 1-800-845-7519.

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 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.

*For more information about limitations and exceptions, see the plan or policy document at: https://www.bbadmin.com/med-spd

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-800-378-1179.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179].

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	$0
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	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,690
The total Peg would pay is	$12,690

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	$0
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	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,240
The total Joe would pay is	$7,240

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

The plan's overall deductible	$0
Specialist copayment	$0
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	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,010
The total Mia would pay is	$2,010

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