




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 visit www.verdegard.com or call 1-877-384-2875. 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 by calling 1-877-384-2875 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Participating Providers : \$0/person; \$0/family Non-Participating Providers : Not Applicable	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive services delivered through a participating physician's office, hospital, or other provider 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 ?	Participating Providers : \$7,900/person; \$15,800/family Non-Participating Providers : Not Applicable	This plan has no out-of-pocket limit . There is no limit on how much you pay during a coverage period for your share of the cost of covered services. However, this plan covers preventive services at 100%. If you seek treatment that is not a preventive services , see the chart on the pages below for your cost and limitations on covered services.
What is not included in the out-of-pocket limit ?	This plan has no out-of-pocket limit .	There is no out-of-pocket limit on your expenses.
Will you pay less if you use a network provider ?	Yes. To find a PHCS provider visit www.multiplan.com or call 1-888-263-7543 or to find a PNOA provider visit www.pnoa.com or call 1-833-257-8179 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 . This plan does not provide coverage if out-of-network provider are used. 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
		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	\$20 Copay /visit	Not Covered	Limited to 3 visits per year.
	Specialist visit	\$50 Copay /visit	Not Covered	Limited to 3 visits per year.
	Preventive care/screening/immunization	Covered in Full	Not Covered	Includes preventive care office visit. Preventive services only, as outlined by the Patient Protection & Affordable Care Act (PPACA). Member is responsible for 100% of billed charges for services other than preventive .
If you have a test	Diagnostic test (x-ray, blood work)	\$50 Copay	Not Covered	Limited to 5 visits per year. Hospital Based: Not Covered
	Imaging (CT/PET scans, MRIs)	\$200 Copay	Not Covered	Limited to 1 visit per year. Hospital Based: Not Covered
If you need drugs to treat your illness or condition More information is available at https://www.medimpact.com/	Generic drugs (Preventive)	Covered in Full	Not Covered	Preventive prescription services as defined by PPACA.
	Generic drugs	\$20 Copay	Not Covered	Generic only up to \$250/prescription.
	Preferred brand drugs	Not Covered	Not Covered	Excluded Service .
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.verdegard.com.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	Excluded Service.
	Physician/surgeon fees	Not Covered	Not Covered	Excluded Service.
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	Excluded Service.
	Emergency medical transportation	Not Covered	Not Covered	Excluded Service.
	Urgent care	\$50 Copay	Not Covered	Limited to 3 visits per year.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	Excluded Service.
	Physician/surgeon fees	Not Covered	Not Covered	Excluded Service.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	Excluded Service.
	Inpatient services	Not Covered	Not Covered	Excluded Service.
If you are pregnant	Office visits	Not Covered	Not Covered	Excluded Service.
	Childbirth/delivery professional services	Not Covered	Not Covered	Excluded Service.
	Childbirth/delivery facility services	Not Covered	Not Covered	Excluded Service.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.verdegard.com.

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 help recovering or have other special health needs	Home health care	Not Covered	Not Covered	Excluded Service.
	Rehabilitation services	Not Covered	Not Covered	Excluded Service.
	Habilitation services	Not Covered	Not Covered	Excluded Service.
	Skilled nursing care	Not Covered	Not Covered	Excluded Service.
	Durable medical equipment	Not Covered	Not Covered	Excluded Service.
	Hospice services	Not Covered	Not Covered	Excluded Service.
If your child needs dental or eye care	Children's eye exam	Covered in Full	Not Covered	Preventive care includes visual screening, as covered under preventive services . (Recommended by Bright Futures project).
	Children's glasses	Not Covered	Not Covered	Excluded Service.
	Children's dental check-up	Covered in Full	Not Covered	Preventive care includes oral health risk assessment, as covered under preventive services . (Recommended by Bright Futures project).

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.verdegard.com.

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"> • Acupuncture • Bariatric surgery • Chiropractic care • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • 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.)
<ul style="list-style-type: none"> • None

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. 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market 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 the 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 1-877-384-2875.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-384-2875.
- Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-384-2875.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-384-2875.

—————*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 at www.verdegard.com.

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](#) \$50
- Hospital (facility) [coinsurance](#) 0%
- Other [cost sharing](#) 0%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic test](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$11,100
The total Peg would pay is	\$11,700

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](#) \$50
- Hospital (facility) [coinsurance](#) 0%
- 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	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$3,900
The total Joe would pay is	\$4,400

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 0%
- 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	\$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$2,300
The total Mia would pay is	\$2,600