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: $10,600/person, $21,200/family Non-Participating Providers: Not Covered	Generally, you must pay all of the costs from provider 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: $10,600/person, $21,200/family Non-Participating Providers: Not Covered	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; charges in excess of the maximum benefits payable under this plan; penalties for failure to obtain pre-authorization; and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. To find a PHCS provider visit www.multiplan.com or call 1-800-922-4362 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 provides limited coverage if out-of-network providers are used **(only emergent services are covered out-of-network)**. 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.

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

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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	0% coinsurance	Not Covered	None
	Specialist visit	0% coinsurance	Not Covered	None
	Preventive care/screening/ immunization	Covered in Full	Not Covered	Preventive services are as outlined by the Patient Protection & Affordable Care Act (PPACA). You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. *
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not Covered	Pre-authorization is required. If you don't get pre-authorization benefits will be denied. *
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.com	Generic drugs (preventive)	Covered in Full	Not Covered	Preventive Prescription Services only as outlined by the PPACA.
	Generic drugs	0% coinsurance	Not Covered	Retail limited to 30-day supply or 90-day supply. Mail order limited to 90-day supply.
	Preferred brand drugs	0% coinsurance	Not Covered	
	Non-preferred brand drugs	0% coinsurance	Not Covered	
	Specialty drugs	0% coinsurance	Not Covered	Limited to 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not Covered	Pre-authorization is required. If you don't get pre-authorization benefits will be denied. *
	Physician/surgeon fees	0% coinsurance	Not Covered	Pre-authorization is required. If you don't get pre-authorization benefits will be denied. *

* 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 immediate medical attention	Emergency room care	0% coinsurance	Not Covered	None
	Emergency medical transportation	0% coinsurance	Not Covered	Pre-authorization is required for non-emergent transportation. If you don't get pre-authorization benefits will be denied. *
	Urgent care	0% coinsurance	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	Not Covered	Pre-authorization is required. If you don't get pre-authorization benefits will be denied. *
	Physician/surgeon fees	0% coinsurance	Not Covered	Pre-authorization is required. If you don't get pre-authorization benefits will be denied. *
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	Not Covered	None
	Inpatient services	0% coinsurance	Not Covered	Pre-authorization is required. If you don't get pre-authorization benefits will be denied. *
If you are pregnant	Office visits	0% coinsurance	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	0% coinsurance	Not Covered	
	Childbirth/delivery facility services	0% coinsurance	Not Covered	Pre-authorization may be required. If you don't get pre-authorization benefits will be denied.*
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not Covered	Limited to 30 visits/year. Pre-authorization is required. If you don't get pre-authorization benefits will be denied. *
	Rehabilitation services	0% coinsurance	Not Covered	Limited to 20 visits/year. Pre-authorization is required. If you don't get pre-authorization benefits will be denied. *
	Habilitation services	0% coinsurance	Not Covered	Limited to 20 visits/year. Pre-authorization is required. If you don't get pre-authorization benefits will be denied. *

* 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)	
	Skilled nursing care	0% coinsurance	Not Covered	Limited to 30 days/year. Pre-authorization is required. If you don't get pre-authorization benefits will be denied. *
	Durable medical equipment	0% coinsurance	Not Covered	Pre-authorization is required if greater than $500/item. If you don't get pre-authorization benefits will be denied. *
	Hospice services	0% coinsurance	Not Covered	Pre-authorization is required. If you don't get pre-authorization benefits will be denied. *
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.)

- 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.)

- 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? **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 1-877-384-2875.
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, kwiijigo 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** **$10,600**
- **Specialist *Coinsurance*** **0%**
- **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	$10,600
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$10,660**

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

- **The plan's overall deductible** **$10,600**
- **Specialist *Coinsurance*** **0%**
- **Hospital (facility) *Coinsurance*** **0%**
- **Other *Cost Sharing*** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic test (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$5,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,420**

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

- **The plan's overall deductible** **$10,600**
- **Specialist *Coinsurance*** **0%**
- **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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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