




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, www.acuity-grp.com or 1-866-569-6092. 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.cciio.cms.gov or call 1-888-866-5311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,000 individual / \$2,000 family. Copayments do not count towards reaching your annual deductible.	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 care and primary care services 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 deductible specific services.
What is the out-of-pocket limit for this plan ?	\$4,000 individual / \$8,000 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, prior authorization/cost containment penalties, 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 ?	Not Applicable for RBP providers.	This plan does not use a provider network . You are encouraged to submit a Provider Nomination to ClaimDOC before your first appointment so they may educate your provider.
	Yes for PPO providers. See www.multiplan.com/phcspracanc 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.

Important Questions	Answers	Why This Matters:
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copayment /office visit	Includes x-rays, tests, inoculations, lab work performed in the provider's office at the time of the appointment. Does not include MRIs, other non-X-ray imaging test, surgery, or chemotherapy.
	Specialist visit	\$50 copayment /office visit	Includes x-rays, tests, inoculations, lab work performed in the provider's office at the time of the appointment. Does not include MRIs, other non-X-ray imaging test, surgery, or chemotherapy.
	Preventive care/screening /immunization	No charge	You may 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. Frequency limits apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at	Generic drugs	\$25 copayment for up to 30-day supply; \$50 copayment for up to 90-day supply through mail order pharmacy	
	Preferred brand drugs	\$50 copayment for up to 30-day supply; \$100 copayment for up to 90-day supply through mail order pharmacy	

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

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
www.truescripts.com or 1-844-257-1955.	Non-preferred brand drugs	\$75 copayment for up to 30-day supply; \$150 copayment for up to 90-day supply through mail order pharmacy	Preauthorization is required for Specialty medications
	Specialty drugs Tier 1 Specialty drugs Tier 2 Specialty drugs Tier 3 Specialty drugs Tier 4 Specialty drugs Tier 5	\$75 copayment for up to 30-day supply 20% copayment up to \$550.00 maximum 20% copayment up to \$2,000.00 maximum 20% copayment 50% copayment	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 copayment applies, then 20% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service.
	Physician/surgeon fees	\$250 copayment applies, then 20% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service.
If you need immediate medical attention	Emergency room care	\$250 copayment applies, then 20% coinsurance	Preauthorization is required within 48 hours, if admitted as an inpatient. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service.
	Emergency medical transportation	20% coinsurance	Non-emergency transport requires Preauthorization . If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service. Only covered if a "prudent" layperson would consider usage appropriate.
	Urgent care	\$75 copayment	Includes routine services (X-rays, surgery, etc.) performed on the same day by same provider. If sent to the ER from Urgent Care, Urgent Care copayment is waived.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copayment , then 20% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service.
	Physician/surgeon fees	\$500 copayment , then 20% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$250 copayment , then 20% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service.
	Inpatient services	\$500 copayment , then 20% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service.
If you are pregnant	Office visits	\$30 copayment /office visit	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	\$500 copayment , then 20% coinsurance	None.
	Childbirth/delivery facility services	\$500 copayment	Preauthorization is required. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service. Maternity Benefits are not covered for enrolled dependent children.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Rehabilitation services	If office-based, \$0 copayment for first 12 visits during the Plan Year; thereafter, \$30 copayment . If hospital-based, deductible applies until met, then 20% coinsurance	Up to 60 maximum visits per Plan Year
	Habilitation services	\$50 copayment	Preauthorization is required. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service. 30 maximum visits per Plan Year.
	Skilled nursing care	20% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service.
	Durable medical equipment	20% coinsurance	Preauthorization is required if charges are greater than \$500. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service.
	Hospice services	No charge	Preauthorization is required. If you don't get preauthorization , benefits will be reduced to 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	N/A
	Children's glasses	Not covered	N/A
	Children's dental check-up	Not covered	N/A

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"> • Bariatric surgery • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Weight loss programs

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

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

- Acupuncture
- Chiropractic care
- Infertility treatment
- Private-duty nursing
- Routine foot 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, or the U. S. Department of Health and Human Services 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 on how 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: the plan sponsor at 1-914-241-4999 or the plan's Claims processor at 1-866-569-6092, or the U. S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 1-866-569-6092.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-569-6092.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-569-6092.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-569-6092.]

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 pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist Copayment](#) \$50
- Hospital (facility) [Coinsurance](#) 20%
- Other [Coinsurance](#) 20%

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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$500
Coinsurance	\$1,900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,460

Managing Joe's Type 2 Diabetes

(a year of routine care of a well- controlled condition)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist Copayment](#) \$50
- Hospital (facility) [Coinsurance](#) 20%
- Other [Coinsurance](#) 20%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$1,300
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,420

Mia's Simple Fracture

(emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist Copayment](#) \$50
- Hospital (facility) [Coinsurance](#) 20%
- Other [Coinsurance](#) 20%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$200
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.