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, visit www.groupresources.com. 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 1-800-749-9963 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network - **$3,000** person **$6,000** family Out-of-network - **$5,000** person **$10,000** family	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 the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. The deductible does not apply to preventive services performed in-network.	This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment 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?	In-network - **$5,000** person **$10,000** family Out-of-network - **$7,000** person **$14,000** 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, balance-billed charges, 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?	Yes. Call PHCS at (877) 952-7427, or visit www.multiplan.com/phcspracanc for a list of participating providers.	You will pay less if you use a provider in the plan's network. Be aware, your network provider may use a non-participating provider for some services. All facility services are subject to Referenced Based Pricing.
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.groupresources.com.]

All **co-payments** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. All services are subject to Referenced Based Pricing.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	20% coinsurance	30% coinsurance	After the deductible, you will pay a $10 co-payment if you receive telephone consultation services through the telemedicine program.
	Specialist visit	20% coinsurance	30% coinsurance	
	Preventive care/screening/ immunizations	No charge Deductible waived	30% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition For more information about prescription drug coverage, visit www.scriptcare.com or www.presmartinc.com	Generic drugs	Retail: $10 co-payment Mail order: $20 co-payment Deductible applies	Not Covered	Covers up to a 30-day (retail through ScriptCare) or 90-day supply (mail order through Prescription Mart)
	Preferred brand drugs	Retail: $35 co-payment Mail order: $70 co-payment Deductible applies	Not Covered	
	Non-preferred brand drugs	50% co-payment to a maximum of $100 per prescription retail or $200 per prescription mail order Deductible applies	Not Covered	
	Specialty drugs	35% co-payment to a maximum of $300 per prescription Deductible applies	Not Covered	Covers up to a 30 day supply (retail through Scriptcare)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Must be pre-certified or benefits will be reduced by $250.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 co-payment per visit plus 20% coinsurance (In-network deductible and out-of-pocket apply to all providers)		Co-payment waived if admitted.
	Emergency medical transportation	20% coinsurance (In-network deductible and out-of-pocket apply to all providers)		All services are subject to Referenced Based Pricing.

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

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Urgent care	$150 co-payment per visit Deductible applies	30% coinsurance	All services are subject to Referenced Based Pricing.
If you have a hospital stay	Facility fee (e.g., hospital room)***	20% coinsurance	30% coinsurance	***Must be pre-certified or a $250 penalty applies.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/behavioral health services and substance use disorder services are covered like any other illness. To determine benefits, please check this grid for the provider or facility that is performing the service		None
	Inpatient services***			***Must be pre-certified or a $250 penalty applies.
If you are pregnant	Office visits	Maternity services are covered like any other illness To determine benefits, please check this grid for the provider or facility that is performing the service		None
	Childbirth/delivery professional services			None
	Childbirth/delivery facility services***			***Pre-certification is not required.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Coverage limited to 100 visits per calendar year.
	Rehabilitation services	20% coinsurance	30% coinsurance	Includes physical, speech & occupational therapy
	Habilitation services	Not covered	Not covered	This exclusion will not apply to Autism, ADD, or ADHD
	Skilled nursing care	20% coinsurance	30% coinsurance	Coverage limited to 100 days per calendar year.
	Durable medical equipment	20% coinsurance	30% coinsurance	Letter of medical necessity required.
	Hospice services	20% coinsurance	30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge Deductible waived	Not Covered	Limited to one exam per 12-month period
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)	
• Bariatric surgery • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S.	• Private duty nursing • Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care (Limited to 26 visits per calendar year)
- Cosmetic surgery (Limited to treatment of congenital birth defects, and treatment of illness or injury when performed within 24 months of such illness or injury)
- Dental care (Adult – limited to treatment of accidental injury to sound natural teeth, and setting of a jaw fractured or dislocated in an accident when treatment is received within 12 months after such accident)
- Infertility treatment (Limited to diagnosis and treatment of underlying medical condition causing infertility - direct attempts to induce pregnancy such as artificial insemination, in vitro fertilization and drug therapy are not covered)
- Routine eye care (Adult - limited to eye exam only; frames, lenses and contacts are not covered)

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: US Dept of Labor, Employee Benefits Security Administration (866) 444-3272 or www.dol.gov/ebsa/healthreform. You may also call Group Resources at (800) 749-9963. 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: Group Resources 770-623-8383 or the Department of Labor's Employee Benefit Security Administration (866) 444-3272 or www.dol.gov/ebsa/healthreform.

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 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: (202) 727-4559

.———————————*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.groupresources.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** **$3,000**
- **Specialist** **20% *coinsurance***
- **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$40
Coinsurance	$1,920
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,020**

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

- **The plan's overall deductible** **$3,000**
- **Specialist** **20% *coinsurance***
- **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$480
Coinsurance	$540
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,080**

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

- **The plan's overall deductible** **$3,000**
- **Specialist** **20% *coinsurance***
- **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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