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.VaultMECs.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 www.healthcare.gov/sbc-glossary/ or call 1-800-318-2596 to request a copy..

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0/Individual or $0/Family**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay,
Are there services covered before you meet your deductible?	**N/A**	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	**N/A**	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?	**Copayment and Coinsurance on certain services, premiums, balance-billing charges, and heath 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, See the www://multiplan.com**	This plan uses a provider network. You will pay less if you use a provider in the plan's network. (**PHCS Practitioner & Ancillary 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 charges and what your plan pays (balance billing). Note: Many services are not paid by the plan if services are provided by an out-of-network provider.
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
		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	$35 Copay	Not Covered	
	Specialist visit	$75 Copay	Not Covered	
	Preventive care/screening/ immunization	$0	Not Covered	Limits & Exceptions may apply, see the Plan Document.
If you have a test	Diagnostic test (x-ray, blood work)	$65 - $150 Copay	Not Covered	Copay dependent on service
	Imaging (CT/PET scans, MRIs)	$600 Copay	Not Covered	Limit 2 per Plan Year.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.VaultMECs.com	Generic drugs	Tier 1: $0 Copay	Not Covered	See formulary for specific drug details
	Preferred brand drugs	Tier 2: $15 or less, Tier 3: $30 or less, Tier 4: $60 or less, Tier 5: Over $60	Not Covered	See formulary for specific drug details. Maximum monthly benefit Individual: $250, Family: $500.
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	
	Physician/surgeon fees	Not Covered	Not Covered	
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	
	Emergency medical transportation	Not Covered	Not Covered	
	Urgent care	$85 Copay	Not Covered	Annual Limits Apply
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	
	Physician/surgeon fees	Not Covered	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	
	Inpatient services	Not Covered	Not Covered	Not Covered

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

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 are pregnant	Office visits	Same as Medical	Same as Medical	
	Childbirth/delivery professional services	Not Covered	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	
	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	Plan pays 100%	No benefit	Screening at least once in all children ages three to five years to detect amblyopia or its risk factors
	Children's glasses	No benefit	No benefit	
	Children's dental check-up	Plan pays 100%	No benefit	At risk assessment for your children ages newborn to age 10

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.)

- Chiropractic services
- Cosmetic surgery or services
- Massage therapy
- Complications of non-covered services
- Rehabilitation services (including cardiac)
- Emergency room services for non-emergent services

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

- Maximum counts for certain services
- Maximum day counts for inpatient services
- Some services are not covered if provided in a hospital setting

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying

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

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: [insert applicable contact information from instructions].

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 1-877-424-2366.

*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	**N/A**
Specialist *[cost sharing]*	**$75**
Hospital (facility) *[cost sharing]*	**N/A**
Other *[cost sharing]*	**N/A**

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**

In this example, Peg would pay:

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

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

The plan's overall deductible	**N/A**
Specialist *[cost sharing]*	**$75**
Hospital (facility) *[cost sharing]*	**N/A**
Other *[cost sharing]*	**N/A**

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	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$**

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

The plan's overall deductible	**N/A**
Specialist *[cost sharing]*	**$75**
Hospital (facility) *[cost sharing]*	**N/A**
Other *[cost sharing]*	**N/A**

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	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$**

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