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, call 877-220-7369. 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.AllThingsVault.com or call 1-877-220-7369 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 Individual / $0 Family	See the common medical events chart below for costs for services the plan covers.
Are there services covered before you meet your deductible?	Yes	Preventative Services as defined in the Affordable Care Act are covered prior to meeting your deductible, check with your **provider** before you get services.
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?	$10,500 Individual. $21,000 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 the **plan**, they have to meet their own **out-of-pocket limit** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premium**, **balance-billing** charges, 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	The **plan** does use a provider **network**. Most benefits are not covered if services are provided by an out of network provider. Check with your **provider** before you get services. See www.multiplan.com or call 1-877-220-7369 for a list of network providers.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose with a **referral**

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies. Plan payment is based on 140% of Medicare Allowable.

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	$25 Copay	Not Covered	Limited to 8 visits per Plan Year. Limit combined with Outpatient Chemical Dependency & Mental Health.
	Specialist visit	$50 Copay	Not Covered	
	Preventive care/screening/ immunization	No Charge	No Charge	You may have to pay for services that aren't Preventive care. Ask your provider's office if the services you need are preventative. Then check what you plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Basic Radiology: $50 Copay Basic Labs:$50 Copay	Not Covered	Combined Limit 3 per Plan Year.
	Imaging (CT/PET scans, MRIs)	$350 Copay	Not Covered	Limit 1 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/ vault-bronze	Generic drugs	Tier 1: $0 Copay for Preventative drugs	Not Covered	Coverage only available for generic drugs as mandated under the Affordable Care Act (ACA).See formulary for drug list and coverage detail.
	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 drug list and coverage detail. Monthly max: $250 Individual & $500 Family
	Specialty drugs	Not Covered	Not Covered	Not Covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	50% Coinsurance	Limit 1 per Plan Year.
	Physician/surgeon fees	Covered	Covered	Included in Facility and Surgery Copay
If you need immediate medical attention	Emergency room care	50% Coinsurance	50% Coinsurance	Limit 1 per Plan Year.
	Emergency medical transportation	Not Covered	Not Covered	
	Urgent care	$50 Copay	Not Covered	Limit 2 visits per Plan Year.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% Coinsurance	50% Coinsurance	Limited to 5 days & 2 Surgeries per Plan Year.
	Physician/surgeon fees	50% Coinsurance	50% Coinsurance	Limited to 5 days & 2 Surgeries per Plan Year.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$50 Copay	Not Covered	Limited to 8 visits per Plan Year. Limit combined with specialist visits.
	Inpatient services	50% Coinsurance	50% Coinsurance	Limited to 5 visits per Plan Year. Limit combined with Inpatient Hospitalization.
If you are pregnant	Office visits	Not Covered	Not Covered	
	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	$25 Copay	Not Covered	Limited to 10 visits per Plan Year.
	Rehabilitation services	Not Covered	Not Covered	None
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Not Covered	Not Covered	None
	Durable medical equipment	Not Covered	Not Covered	None
	Hospice services	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Only as defined as preventative in the Affordable Care Act
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	No Charge	Not Covered	Only as defined as preventative in the Affordable Care Act

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.)		
• Dental Care	• Private Duty Nursing	• Infertility Treatment
• Most services provided in a hospital		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Most medical services have annual limits	• Most diagnostic services

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 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 1-877-220-7369.

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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 [cost sharing]*** **$50**
- **Hospital (facility) *[cost sharing]*** **$350**
- **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	**$12,124**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$750
Coinsurance	$0
What isn't covered	
Limits or exclusions	$8,271
The total Peg would pay is	**$9,021**

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 [cost sharing]*** **$50**
- **Hospital (facility) *[cost sharing]*** **$350**
- **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	**$5,887**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,621
The total Joe would pay is	**$4,971**

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

- **The plan's overall deductible** **$0**
- ***Specialist [cost sharing]*** **$50**
- **Hospital (facility) *[cost sharing]*** **$350**
- **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	**$2,923**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$550
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,432
The total Mia would pay is	**$1,982**

This plan includes benefit limits and exclusions that may impact these examples.