

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.AllThingsVault.com/2022MEC](http://www.AllThingsVault.com/2022MEC). 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/](http://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 <a href="#">deductible</a> ?	\$0 individual / \$0 family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventative care</a> , <a href="#">genericpreventative drugs</a> and \$0 Copay Telemedicine services are covered.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Forexample, this <a href="#">plan</a> covers certain <a href="#">preventative services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventative services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocketlimit</a> for this <a href="#">plan</a> ?	\$5,000 individual/ \$10,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.multiplan.com">www.multiplan.com</a> or call 1-877-952-7427for a list of network providers.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . In office services are only covered when you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . If you use an <a href="#">out-of-network provider</a> , you will likely receive a bill from a <a href="#">provider</a> for services ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your provider before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	<a href="#">Specialist</a> services must be provided by an in-network provider, per visit co-payment will apply.

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)	
<b>If you visit a health care <a href="#">provider's office or clinic</a></b>	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a>	Not covered	Not covered if provided at a hospital. Limited to 10 visits per plan year.
	<a href="#">Specialist</a> visit	\$25 <a href="#">copay</a>	Not covered	Not covered if provided at a hospital. Limited to 10 visits per plan year.
	<a href="#">Preventative care/screening/immunization</a>	No charge	Not covered	Not covered if provided at a hospital. <a href="#">Plan</a> pays 100% of covered <a href="#">preventative and wellness services</a> . You may have to pay for services that aren't preventative. <a href="#">Deductible</a> does not apply.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 <a href="#">copay</a>	Not covered	Not covered if services are provided at a hospital. Combined limit of 3 visits per plan year for Laboratory Services and Radiology.
	Imaging (CT/PET scans, MRIs)	\$350 <a href="#">copay</a> (Subject to Reference Based Pricing)	Not covered	Not covered if services are provided at a hospital. Limited to 2 per plan year. <a href="#">Preauthorization</a> is required.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.AllThingsVault.com/2022MEC">www.AllThingsVault.com/2022MEC</a>	Generic drugs	Covered 100% for preventative, co-payments apply for other generic drugs, see formulary	Not covered	Limited to preventative generic drugs. See Formulary posted online at <a href="http://www.AllThingsVault.com/2022MEC">www.AllThingsVault.com/2022MEC</a>
	Preferred brand drugs	See Formulary posted online at <a href="http://www.AllThingsVault.com/2022MEC">www.AllThingsVault.com/2022MEC</a>	Not covered	See Formulary posted online at <a href="http://www.AllThingsVault.com/2022MEC">www.AllThingsVault.com/2022MEC</a>
	Non-preferred brand drugs	See Formulary posted online at <a href="http://www.AllThingsVault.com/2022MEC">www.AllThingsVault.com/2022MEC</a>	Not covered	See Formulary posted online at <a href="http://www.AllThingsVault.com/2022MEC">www.AllThingsVault.com/2022MEC</a>
	<a href="#">Specialty drugs</a>	See Formulary posted online at <a href="http://www.AllThingsVault.com/2022MEC">www.AllThingsVault.com/2022MEC</a>	Not covered	See Formulary posted online at <a href="http://www.AllThingsVault.com/2022MEC">www.AllThingsVault.com/2022MEC</a>

\* For more information about limitations and exceptions, see the plan or policy document.

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$350 <a href="#">copay</a>	\$350 <a href="#">copay</a>	Limited to 3 visit per plan year. <a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	Covered	Covered	Included in Inpatient Hospitalization or Outpatient Hospital or Free Standing Facility Services and Surgery Copay.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$350 <a href="#">copay</a> .	\$350 <a href="#">copay</a>	Emergency room stay over 24 hours will be considered inpatient hospitalization. This <a href="#">plan</a> does not utilize a <a href="#">network</a> for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate. Limited to 1 visit per plan year.
	<a href="#">Emergency medical transportation</a>	\$250 <a href="#">copay</a> . (Subject to Reference Based Pricing)	\$250 <a href="#">copay</a> . (Subject to Reference Based Pricing)	By land only. Limited to 1 transport per plan year.
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a>	Not covered	Not covered if provided at a hospital. Limited to 3 visit per plan year.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$350 <a href="#">copay</a> per admission	\$350 <a href="#">copay</a> per admission	This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to reference based pricing reimbursements based on the Medicare reimbursement rate. Neonatal Intensive Care (NICU) is not covered. <a href="#">Preauthorization</a> is required. Limited to 7 days per plan year
	Physician/surgeon fees	Included in Inpatient Hospitalization <a href="#">copay</a>	Included in Inpatient Hospitalization <a href="#">copay</a>	Not covered
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copay</a> per day	Not covered	Not covered if provided at a hospital. Considered a <a href="#">specialist</a> visit. Limited to mental & behavioral health or substance abuse. <a href="#">Preventative services</a> are covered for mental, behavioral health or substance abuse. <a href="#">Cost sharing</a> does not apply for <a href="#">preventative services</a> . Partial hospitalization is not covered.
	Inpatient services	\$350 <a href="#">copay</a> per day (Subject to Reference Based Pricing)	\$350 <a href="#">copay</a> per day (Subject to Reference Based Pricing)	Not covered if services are provided at a hospital. Treatment for Chemical Abuse & Dependency only. Limited to 7 days per plan year. Preventative services are covered for mental, behavioral health or substance abuse. <a href="#">Cost sharing</a> does not apply for preventative services. <a href="#">Preauthorization</a> is required.
<b>If you are pregnant</b>	Office visits	Included In Professional Services <a href="#">copay</a>	Not covered	See Professional Services limitations.
	Childbirth/delivery professional services	\$350 <a href="#">copay</a>	Not covered	Professional Services only, including standard office visits.
	Childbirth/delivery facility services	\$350 <a href="#">copay</a> per admission (Subject to Reference Based Pricing)	\$350 <a href="#">copay</a> per admission (Subject to Reference Based Pricing)	Considered an Inpatient Hospital Stay.

\* For more information about limitations and exceptions, see the plan or policy document.

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 help recovering or have other special health needs	<a href="#">Home health care</a>	\$25 <a href="#">copay</a>	Not covered	Limited to 10 visits per plan year.
	<a href="#">Rehabilitation services</a>	Not covered	Not covered	Not covered
	<a href="#">Habilitation services</a>	Not covered	Not covered	Not covered
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	Not covered
	<a href="#">Durable medical equipment</a>	Not covered	Not covered	Not covered
	<a href="#">Hospice services</a>	Not covered	Not covered	Not covered
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	One vision screening for children 3-5 years is covered as a <a href="#">preventative service</a> . Cost sharing does not apply for preventative services.
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Dental caries fluoride application for infants and children up to 5 years are covered as <a href="#">preventative services</a> . <a href="#">Cost sharing</a> does not apply for <a href="#">preventative services</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](#).)**

This plan is a limited medical plan and excludes the following: Acupuncture, Infertility Treatment, Weight Loss Programs, Bariatric Surgery, Long Term Care, Chiropractic Care, Non-emergency care when traveling outside the U.S., Cosmetic Surgery, Private Duty Nursing, Dental Care (except as noted above), Vision Services (except as noted above), Durable Medical Devices, Routine Foot Care, and other Voluntary Procedures.

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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: 1-877-813-2685.

**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? No**

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 1-877-813-2685.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-813-2685.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-813-2685.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-877-813-2685.

----- 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.

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.

Bridget is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Doug's type 2 Diabetes (a year of routine in-network care of a well- controlled condition)		Blaine's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [copay]	\$25	■ <a href="#">Specialist</a> [copay]	\$25	■ <a href="#">Specialist</a> [copay]	\$25
■ Hospital (facility) [copay]	\$350	■ Hospital (facility) [copay]	\$350	■ Hospital (facility) [copay]	\$350
■ Other [cost sharing]	0%	■ Other [cost sharing]	0%	■ Other [cost sharing]	0%
<p>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)</p>		<p>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)</p>		<p>This EXAMPLE event includes services like:                      Emergency room care (including medical supplies)                      Diagnostic test (x-ray)                      Durable medical equipment (crutches)                      Rehabilitation services (physical therapy)</p>	
<b>Total Example Cost</b>	<b>\$13,252</b>	<b>Total Example Cost</b>	<b>\$8,056</b>	<b>Total Example Cost</b>	<b>\$1,984</b>
In this example, Bridget would pay:		In this example, Doug would pay:		In this example, Blaine would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$1,300	Copayments (for generic drugs, see formulary)	\$925	Copayments	\$1,075
Coinsurance	\$0	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$132	Limits or exclusions	\$5,962	Limits or exclusions	\$721
<b>The total Bridget would pay is</b>	<b>\$1,432</b>	<b>The total Doug would pay is</b>	<b>\$6,887</b>	<b>The total Blaine would pay is</b>	<b>\$1,796</b>

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