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 1-866-393-2303. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You may view the Glossary at healthcare.gov /sbc-glossary or call 1-866-393-2303 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1---Single Plan: $1,000 employee Family Plan: $1,000 person/$2,750 family Tiers 2 & 3---Single Plan: $1,200 employee Family Plan: $1,200 person/$3,600 family	Generally, you must pay all costs from providers up to 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 total amount of deductible expenses paid by all family members meets overall family deductible.
Are there services covered before you meet your deductible?	Tier 1--Yes. Preventive services and physician office visits are some of services covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met 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 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?	Single Plan: $4,000 employee Family Plan: $4,000 person/$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 is met.
What is not included in the out-of-pocket limit?	Preauthorization penalties, premiums, 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. See MyVHN.com or call 1-866-393-2303 for a list of network providers.	You pay the least if you use a Tier 1 provider. You may pay more if you use a Tier 2 or 3 provider. You pay the most if you use an out-of-network provider (Tier 4) 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.
Do you need a referral to see a specialist?	No.	You may see a 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
		Local Network [Tier 1] (You pay least)	Extended Network [Tier 2] (You may pay more)	Specialty Network [Tier 3] (You may pay more)	Out-of-Network [Tier 4] (You pay most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury/illness	$30 copay/visit; deductible waived		Not covered		You may have to pay for services that aren't preventive. Ask provider if services are preventive. Then check what plan will pay.
	Specialist visit	$45 copay/visit; deductible waived	25% coinsurance	25% coinsurance	Not covered	
	Preventive care/ Screening/Immunization	No charge; deductible waived		Not covered		
If you have a test	Diagnostic test (Outpatient) ---X-rays/ultrasounds @ Stand-alone facility or Physician's Office @ Outpatient Hospital ---Blood Work @ Halifax Hospital @ All Other Facilities	$35 copay; deductible waived 10% coinsurance No charge; deductible waived 10% coinsurance	25% coinsurance	25% coinsurance	Not covered	None
	Imaging (CT/PET scan, MRI)--- Stand-alone outpatient facility or Physician's Office Halifax Hospital	$150 copay; deductible waived 10% coinsurance				

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
		Local Network [Tier 1] (You pay least)	Extended Network [Tier 2] (You may pay more)	Specialty Network [Tier 3] (You may pay more)	Out-of-Network [Tier 4] (You pay most)	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at MyVHN.com	Tier 1: Preferred Generic drugs: Halifax In-House Pharmacy & Publix →up to 31-day or 93-day supply →32 to 60-day supply →61 to 93–day supply Publix Mail Order--up to 93-day supply	 $7 copay/script $14 copay/script $21 copay/script $18 copay/script			If you use non-contracted pharmacies to fill prescriptions for emergency reasons, you pay out-of-pocket & submit to plan for reimbursement after applicable copay plus an additional $5 copay	Deductible waived.
	Tier 2: Non-Preferred Generic drugs: Halifax In-House Pharmacy & Publix →up to 31-day or 93-day supply →32 to 60-day supply →61 to 93–day supply Publix Mail Order--up to 93-day supply	 $15 copay/script $30 copay/script $45 copay/script $42 copay/script				
	Tier 3: Preferred brand drugs: Halifax In-House Pharmacy & Publix →up to 31-day or 93-day supply →32 to 60-day supply →61 to 93–day supply Publix Mail Order--up to 93-day supply	 $37 copay/script $74 copay/script $111 copay/script $108 copay/script				
	Tier 4: Non-Preferred brand drugs: Halifax In-House Pharmacy & Publix →up to 31-day or 93-day supply →32 to 60-day supply →61 to 93–day supply Publix Mail Order--up to 93-day supply	 $65 copay/script $139 copay/script $195 copay/script $192 copay/script				
	Specialty drugs through Publix	20% coinsurance for up to 31-day supply				
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center, Hospital, etc.)	$500 copay/visit; deductible waived	25% coinsurance	25% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	25% coinsurance	25% coinsurance	Not covered	

Preauthorization is required for outpatient services & inpatient admissions. You pay 50% of the billed charges for failure to obtain preauthorization at a Tier 1 facility and 100% of the billed charges at a Tier 2 or 3 facility.

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
		Local Network [Tier 1] (You pay least)	Extended Network [Tier 2] (You may pay more)	Specialty Network [Tier 3] (You may pay more)	Out-of-Network [Tier 4] (You pay most)	
If you need immediate medical attention	Emergency room care	$250 copay/visit; deductible waived				Copay waived if admitted
	Emergency medical transportation	10% coinsurance	25% coinsurance after Tier 2 deductible			Preauthorization required for Air Ambulance Services
	Urgent care	$60 copay/visit; deductible waived		Not covered		None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/day up to $500/admission then deductible thereafter	25% coinsurance	25% coinsurance	Not covered	Preauthorization required
	Physician/surgeon fees	10% coinsurance	25% coinsurance	25% coinsurance	Not covered	
If you need mental health, behavioral health or substance abuse services	Outpatient services— Office Visit	$30 copay/visit;* deductible waived	25% coinsurance	25% coinsurance	Not covered	*Copays for Office Visits limited to $500/yr. Preauthorization required for Intensive outpatient treatment & Inpatient services
	Intensive outpatient treatment	No charge; deductible waived				
	Inpatient services	$100 copay/day up to $500/admission then deductible thereafter				
If you are pregnant	Office visits	No charge; deductible waived	No charge; deductible waived	No charge; deductible waived	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Requires preauthorization for stays over 48 hrs (normal delivery) or 96 hrs (caesarean).
	Childbirth/delivery professional services	10% coinsurance	25% coinsurance	25% coinsurance		
	Childbirth/delivery facility services	$100 copay/day up to $500/admission then deductible thereafter	25% coinsurance	25% coinsurance		
If you need help recovering or have other special health needs	Home health care	10% coinsurance	25% coinsurance	25% coinsurance	Not covered	Preauthorization required. 44 visits/yr
	Rehabilitation services— Inpatient	10% coinsurance	25% coinsurance	25% coinsurance	Not covered	Requires preauthorization for Inpatient. 24 visits/yr each for Occupational, Physical & Speech therapies.
	Outpatient	10% coinsurance	25% coinsurance	25% coinsurance	Not covered	

Preauthorization is required for outpatient services & inpatient admissions. You pay 50% of the billed charges for failure to obtain preauthorization at a Tier 1 facility and 100% of the billed charges at a Tier 2 or 3 facility.

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
		Local Network [Tier 1] (You pay least)	Extended Network [Tier 2] (You may pay more)	Specialty Network [Tier 3] (You may pay more)	Out-of-Network [Tier 4] (You pay most)	
If you need help recovering or have other special health needs (continued)	Habilitation services— Early Intervention Developmental Delay	 10% coinsurance 10% coinsurance	 25% coinsurance 25% coinsurance	 25% coinsurance 25% coinsurance	 Not covered Not covered	 Up to age 3 24 visits/yr/therapy
	Skilled nursing care	10% coinsurance	25% coinsurance	25% coinsurance	Not covered	90 days/yr. Requires preauthorization
	Durable medical equipment	10% coinsurance	25% coinsurance	25% coinsurance	Not covered	Preauthorization required for rental over 3 months, equipment over $1,000 & implantable loop recorders.
	Hospice services	10% coinsurance	25% coinsurance	25% coinsurance	Not covered	Preauthorization required
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
Preauthorization is required for outpatient services & inpatient admissions. You pay 50% of the billed charges for failure to obtain preauthorization at a Tier 1 facility and 100% of the billed charges at a Tier 2 or 3 facility.						

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (routine child & adult)
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside U.S.
- Private duty nursing
- Routine eye care (child & adult)
- Routine foot care

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

- Bariatric surgery
- Chiropractic care (24 visits/yr)
- Weight loss programs (for bariatric surgery candidates only)

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 the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-EBSA (3272) or 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 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, you can contact the plan at 1-866-393-2303. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (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 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 1-866-393-2303
Portuguese (Português): De assistência em Português, ligue 1-866-393-2303
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-393-2303

[———————*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	**$1,000**
Specialist copayment	**$45**
Hospital (facility) copayment	**$500**
Other copayment	**$35**

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	$1,000
Copayments	$600
Coinsurance	$40
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,700**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$45**
Hospital (facility) copayment	**$500**
Other coinsurance	**10%**

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	$800
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$45**
Hospital (facility) copayment	**$500**
Other coinsurance	**10%**

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	$1,000
Copayments	$500
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,560**