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, XXX-XXX-XXXX (Sales Team Phone Number) or view additional online information at 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/ or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall **deductible**?	$1,000 individual / $2,000 family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your **deductible**?	Yes. Preventive care, generic preventive drugs and $0 Copay Telemedicine services are covered.	This plan covers some items and services even if you haven't yet met the 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 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**?	N/A	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-billing charges, and health care this plan doesn't cover.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a **network provider**?	Yes. See www.psiproviderlookup.com or call 1-866-244-7796 for a list of network providers.	This plan uses a provider network. In office services are only covered when you use a provider in the plan's network. If you use an out-of-network provider, you will likely receive a bill from a provider for services (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.	Specialist 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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Telemedicine Visits covered 100% or $35 co-payment for Primary care office visit	Not covered	Please consider using Telemedicine services first, but prior authorization is not required. In-network only providers are covered, look up providers at www.PSIProviderLookup.com
	Specialist visit	$75 co-payment	Not covered	Please consider using Telemedicine services first, but prior authorization is not required. In-network only providers are covered, look up providers at www.PSIProviderLookup.com
	Preventive care/screening/ immunization	No charge	Not covered	Not covered if provided at a hospital. Plan pays 100% of covered preventive and wellness services. You may have to pay for services that aren't preventive. Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	$50 co-payment for x-ray, $100 co-payment for each bloodwork panel	Not covered	Not covered if provided at a hospital
	Imaging (CT/PET scans, MRIs)	$500 per image billed	Not covered	Not covered if provided at a hospital
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling XXX-XXX-XXXX or online at www.AllThingsVault.com/2022MEC	Generic drugs	Covered 100% for preventive, co-payments apply for other generic drugs, see formulary	Not covered	See Formulary posted online at www.AllThingsVault.com/2022MEC.
	Preferred brand drugs	Not covered	Not covered	Not covered
	Non-preferred brand drugs	Not covered	Not covered	Not covered
	Specialty drugs	Not covered	Not covered	Not covered

* 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered	Not covered
If you need immediate medical attention	Emergency room care	After deductible, $400 co-payment then 50% co-insurance. Limited to one visit per plan year.	Not covered	Please consider using Telemedicine services first, but prior authorization is not required. In-network only providers are covered, look up providers at www.PSIProviderLookup.com
	Emergency medical transportation	Not covered	Not covered	Not covered
	Urgent care	$150 co-payment	Not covered	Not covered if provided at a hospital.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	Not covered
	Physician/surgeon fees	Not covered	Not covered	Not covered
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Not covered
	Inpatient services	After deductible, $500 co-payment then 60% co-insurance for Room & Board only, combined limit of 5 days.	Not covered	Not covered
If you are pregnant	Office visits	Specialist co-payment	Not covered	In-network provider with prior-authorization from Telemedicine service
	Childbirth/delivery professional services	Not covered	Not covered	Not covered
	Childbirth/delivery facility services	Same as Inpatient Services	Not covered	Not covered

* 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	Home health care	Not covered	Not covered	Not covered
	Rehabilitation services	Not covered	Not covered	Not covered
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	Not covered	Not covered	Not covered
	Durable medical equipment	Not covered	Not covered	Not covered
	Hospice services	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 preventive service. Cost sharing does not apply for preventive 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 preventive services. Cost sharing does not apply for preventive services.

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 is a limited benefit plan. Plan only covers Telemedicine Services, Primary Care services for preventative services and a limited number of other services as identified in this document and the full-plan document. All services must be provided by an in-network provider only in person services unless an in-network provider is not available in your geographic location. The plan does provide a pharmacy drug benefit, please see the formulary for details. All other medical services are not covered by this plan.

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. 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: 1-866-298-9848.

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 1-866-298-9848
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-298-9848
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1866-298-9848
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-298-9848

——————— 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)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$75
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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	**$13,252**

In this example, Bridget would pay:

Cost Sharing	
Deductibles	$0
Copayments	$450
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,352
The total Bridget would pay is	**$12,802**

Managing Doug'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]*	$75
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	$300

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	**$8,056**

In this example, Doug would pay:

Cost Sharing	
Deductibles	$0
Copayments (for generic drugs)	$1,230
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Doug would pay is	**$5,530**

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$75
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	$65

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	**$1,984**

In this example, Blaine would pay:

Cost Sharing	
Deductibles	$0
Copayments	$210
Coinsurance	$0
What isn't covered	
Limits or exclusions	$645
The total Blaine would pay is	**$855**

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