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.groupresources.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 https://www.healthcare.gov/sbc-glossary or call 1-800-749-9963 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$441** employee **$882** employee plus one dependent **$1,333** family	Generally, you must pay all of the costs from providers up to the 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 the total amount of the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. The deductible does not apply to prescriptions, home health care, hospice care, or to preventive services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment 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?	**$3,057** per person	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?	Deductibles, premiums, balance-billed charges, penalties, 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 www.pbhn.org or www.multiplan.com for a list of participating providers.	You will pay less if you use a provider in the plan's 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 charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

All 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	10% coinsurance PBHN 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	None
	Specialist visit	10% coinsurance PBHN 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	None
	Preventive care/screening/ Immunizations	No charge for first $300 then 10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. **Gardasil vaccine is not covered.**
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	None
If you need drugs to treat your illness or condition For more information about drug coverage, visit www.medtrakservices.com or call (800) 771-4648	Generic drugs	$6 retail (30) - $12 retail (90) $12 mail order (90)	Not covered	Covers up to a 30-day or 90 day supply retail and a 90 day supply mail order
	Preferred brand drugs	$30 retail (30) - $60 retail (90) $60 mail order (90)	Not covered	
	Prescription drugs costing $250 or more retail/ $750 or more mail order	$60 retail (30) - $120 retail (90) $120 mail order (90)	Not covered	
	Prescription drugs costing $1,000 or more retail/ $3,000 or more mail order	$60 plus 30% of retail cost (30) $120 plus 30% of retail cost (90) $120 plus 30% of mail order cost (90)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) and Physician/surgeon fees	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	None

[* For more information about limitations and exceptions, see the plan or policy document at www.groupresources.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 need immediate medical attention	Emergency room care	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area and out-of-network		None
	Emergency medical transportation	20% coinsurance PPO 20% coinsurance out of area and out-of-network		None
	Urgent care	10% coinsurance PBHN 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room) and Physician/surgeon fees	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	Inpatient services must be pre-certified or a $500 penalty will apply
If you need mental health, behavioral health, or substance abuse services	Outpatient services and Inpatient services	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	Inpatient services must be pre-certified or a $500 penalty will apply
If you are pregnant	Office visits Childbirth/delivery professional services and facility services	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No charge		None
	Rehabilitation services Habilitation services	10% coinsurance PBHN physician 20% coinsurance PBHN facility 20% coinsurance PPO 30% coinsurance out of area	40% coinsurance	50 visits per calendar year per type of therapy
	Skilled nursing care			60 days per calendar year
	Durable medical equipment			Letter of medical necessity is required
	Hospice services	No charge		None
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	Covered under Preventive care
	Children's glasses	Not covered		None
	Children's dental check-up	See separate dental plan – not covered by medical plan		None

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

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.)
• Bariatric surgery • Hearing Aids • Long-term care • Non-emergency care if traveling outside the U.S. • Routine eye care (Adult) • Routine foot care • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• Acupuncture • Chiropractic care (Limited to 26 visits per calendar year) • Cosmetic surgery (Covered only when required due to illness or injury and when performed within 12 months of such illness or injury, or because of congenital birth defects, trauma, tumors, or developmental deformities) • Dental care (Adult – limited to emergency repair of accidental injury to sound natural teeth including the replacement of such teeth or setting of a jaw fractured or dislocated in an accident when treatment is received within six months of such accident; cutting procedures in the oral cavity for tumors or cysts of the jawbone; treatment of fractures and traumatic dislocations of the jawbone; cutting procedures on gums or mouth tissues needed to treat a disease; and the removal of impacted teeth) • Infertility treatment (Covered only if plan criteria are met) • Private duty nursing (Covered only when medically necessary – prior approval is required)

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: US Dept of Labor, Employee Benefits Security Administration (866) 444-3272 or www.dol.gov/ebsa/healthreform. You may also call Group Resources at (800) 749-9963. 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: Group Resources 770-623-8383 or the Department of Labor's Employee Benefit Security Administration (866) 444-3272 or www.dol.gov/ebsa/healthreform.

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? 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: (202) 727-4559

.————————————*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 at www.groupresources.com.]

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	$441
Specialist *coinsurance*	10%
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	10%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$440
Copayments	$40
Coinsurance	$2250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2790**

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

The plan's overall deductible	$441
Specialist *coinsurance*	10%
Hospital (facility) *coinsurance*	20%
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$440
Copayments	$575
Coinsurance	$250
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1325**

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

The plan's overall deductible	$441
Specialist *coinsurance*	10%
Hospital (facility) *coinsurance*	20%
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$440
Copayments	$0
Coinsurance	$250
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$690**

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