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 1-888-472-4352. 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 1-888-472-4352 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For PHN Employee Plan Network providers $0; For out-of-network provider $1,000/individual, $3,000/family	If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, there is no deductible for the PHN Employee Plan Network.	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. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For PHN Employee Plan Network providers $1,500/individual, $4,500/family; For out-of-network provider: unlimited	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 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 (unless balance billing is prohibited), health care this plan doesn't cover, and penalties for failure to obtain pre-certification for services.	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. Yes, this plan uses the PHN Employee Plan Network. See www.myGilsbar.com or call 1-888-472-4352 for a list of network providers.	This plan uses a provider network. 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). 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 can see the 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
		PHN Employee Plan 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	$20 copay/visit No charge for other outpatient services	30% coinsurance	Copay is per provider and applies to office visits, allergy testing and treatment, injections, supplies, and minor office surgery, including vasectomies. Precertification is required for certain surgeries in the office or services may not be covered.
	Specialist visit	$20 copay/visit No charge for other outpatient services	30% coinsurance	
	Preventive care/screening/ immunization	No charge	30% coinsurance	Includes but is not limited to: routine physical exam, x-ray/lab, gynecological exam, well woman visit, immunizations, mammogram, pap smear, prostatic/ testicular exam, colonoscopies and services as required by law. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	
	Imaging (CT/PET scans, MRIs)	$50 copay/visit	30% coinsurance	Precertification is required for MRAs, CTAs, and angiograms or services may not be covered.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PHN Employee Plan Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myGilsbar.com	Tier 1 (includes generic drugs)	Copay/prescription 30-day supply: $5 90-day supply: $10	Not covered	Covers up to a 30-day supply at retail pharmacies; 90-day supply maintenance prescriptions at retail pharmacies and through the mail order pharmacy. Preventive medication and contraceptives are covered at no charge as required by law. Precertification is required for high cost injectable drugs over $2,000 or the drug may not be covered. Restrictions such as quantity limits, step therapy, and prior authorization may apply to certain prescriptions.
	Tier 2 (includes preferred brand name drugs)	Copay/prescription 30-day supply: $35 90-day supply: $70	Not covered	
	Tier 3 (includes non-preferred brand name drugs)	Copay/prescription 30-day supply: $55 90-day supply: $110	Not covered	
	Tier 4 (includes specialty drugs)	Copay/prescription 30-day supply: $85 90-day supply: $170	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit	30% coinsurance	Precertification is required or services may not be covered.
	Physician/surgeon fees	No charge	30% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/visit	Emergencies: $150 copay/visit, deductible does not apply Non-emergencies: 30% coinsurance	Copay is waived if you are admitted directly to the hospital from the emergency room within 24 hours.
	Emergency medical transportation	$100 copay/visit	$100 copay/visit, deductible does not apply	
	Urgent care	$75 copay/visit	$75 copay/visit, deductible does not apply	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PHN Employee Plan Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/day, up to 3 days per admission	30% coinsurance	Precertification is required or services may not be covered.
	Physician/surgeon fees	No charge	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	30% coinsurance	Optum is the network for these services. You may contact Optum toll-free at 1-877-566-7913 or visit www.peopleshealth.com/bhemp. Precertification is required for inpatient stay or services may not be covered.
	Inpatient services	$250 copay/day, up to 3 days per admission	30% coinsurance	
If you are pregnant	Office visits	$50 copay (comprehensive)	30% coinsurance	Cost sharing does not apply for PHN Employee Plan Network Provider preventive services. Precertification is required or services may not be covered for an inpatient stay that is in excess of 48 hours (vaginal delivery) or 96 hours (caesarean delivery).
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	$250 copay/day, up to 3 days per admission	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Precertification is required for all home infusion over $2,000 or services may not be covered.
	Rehabilitation services	$20 copay/visit	30% coinsurance	Physical therapy, occupational therapy, and speech therapy are limited to a combined total of 60 visits/calendar year. No coverage for vision therapy.
	Habilitation services	$20 copay/visit	30% coinsurance	Coverage is provided only for Autism Spectrum Disorders (includes services such as Applied Behavioral Analysis) and for speech therapy when a significant improvement of the condition can be expected in a 60-day period. Speech therapy is subject to the limits shown above.
	Skilled nursing care	$250 copay/day, up to 3 days per admission	30% coinsurance	Precertification is required or services may not be covered. Limited to 60 days per calendar year.

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

	Durable medical equipment	No charge	30% coinsurance	Purchases only if less expensive than rental; replacement only after 5 years. Precertification is required for equipment over $1,000, orthotics, and prosthetics or items many not be covered.
	Hospice services	No charge	Not covered	Benefit does not include bereavement counseling.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for children's eye exam.
	Children's glasses	Not covered	Not covered	No coverage for children's glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

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 (Adult) / (Child)
- Glasses
- Hearing aid
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult) / (Child)
- Routine foot care, unless associated with diseases affecting the lower limbs
- Weight loss programs
- Vision therapy

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

- Bariatric surgery that is medically necessary
- Chiropractic care
- Habilitation Services, limited as described above

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-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, contact: Claims Administrator: Gilsbar, Inc. | 1-888-472-4352 | www.myGilsbar.com or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

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 1-888-472-4352.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-472-4352.

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-888-472-4352.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-472-4352.

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	$0
Specialist copayments	$20
Hospital (facility) coinsurance	0%
Other coinsurance	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	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$810
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$870

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 copayments	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$810
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$870

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

The plan's overall deductible	$0
Specialist copayments	$20
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,010

In this example, Mia would pay:

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

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator, P.O. Box 998, Covington, LA 70433, Phone: 1-888-472-4352, TTY: 711, Fax: 985-898-1636, CivilRightsCoordinator@gilsbar.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish:	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-472-4352. (TTY: 711).
French:	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-472-4352. (ATS: 711).
Vietnamese:	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-472-4352. (TTY: 711).
Chinese:	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-472-4352。(TTY: 711).
Arabic:	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-472-4352 (رقم هاتف الصم والبكم:711).

Tagalog:	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-472-4352. (TTY: 711).
Korean:	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-472-4352 (TTY: 711)번으로 전화해 주십시오.
Portuguese:	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-472-4352. (TTY: 711).
Laotian:	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-472-4352 (TTY: 711).
Japanese:	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-472-4352（TTY:711）まで、お電話にてご連絡ください。
Urdu:	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-888-472-4352 (TTY: 711).
German:	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-472-4352 (TTY: 711).
Farsi:	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-472-4352 (TTY: 711) تماس بگیرید.
Russian:	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-472-4352 (телетайп: 711).
Thai:	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-472-4352 (TTY: 711).
Gujarati:	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-472-4352 (TTY: 711).
Hindi:	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-472-4352 (TTY: 711) पर कॉल करें।
Hmong:	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-472-4352 (TTY: 711).
Navajo:	D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-888-472-4352 (TTY: 711.)
Syriac:	ܙܘܗܪܐ: ܐܢ ܐܢܬ ܡܡܠܠܐ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬ ܕܩܒܠܬ ܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܕܝܠܟ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 1-888-472-4352 (TTY: 711)
Cambodian:	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-472-4352 (TTY: 711)។
Serbo-Croatian:	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-472-4352 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
Amharic:	ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-472-4352 (መስማት ለተሳናቸው: 711).
Haitian Creole:	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-472-4352 (TTY: 711).