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 386.425.4846. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. To view the glossary, visit www.healthcare.gov/sbc-glossary .

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Local Network: $500 Individual/$1,500 Family Extended/Specialty Network: $800 Individual/$1,850 Family No Out-of Network Coverage.	Deductible applies to most services. You must meet this deductible amount of cost from providers before this plan begins to pay. Each family member in the plan must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. The deductible requirement applies once per calendar year.
Are there services covered before you meet your deductible?	Yes. Preventive Care, Primary Care and services with a Co-Payment are not subject to the deductible.	This plan covers some items and services even if you have not met the deductible amount. A co-payment or co-insurance may apply.
Are there other deductibles for specific services?	One deductible applies across all applicable services.	You do not have to meet deductibles for specific services. Refer to the Plan Matrix of the Quick Reference Guide to review where the plan deductible may apply.
What is the out-of-pocket limit for this plan?	$3,000 Individual/ $6,000 Family	The out-of-pocket limit is the most you will pay for your share of covered services during a calendar year. Includes deductible, Coinsurance and Copays for medical and pharmacy.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain a precertification for services, out-of-network provider services not covered.	Although these are costs you are responsible for paying, these expenses do not count towards your out-of-pocket limit.
Will you pay less if you use a network provider?	Yes.	There is no coverage for out-of-network providers.
Do you need a referral to see a specialist?	No, you do not need a referral to see a specialist in the Local network. Out-of Network provider services are not covered.	You can see any Local Network specialist you choose without a referral, however, precertification may apply for certain services your specialist orders. Although no referral is required, use of the plan's Extended or Specialty Network providers will require precertification.

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	$30 Local Network only /visit	Not covered	Additional cost share applies for allergy shots & some other procedures
	Specialist visit	$45 Local Network/visit 25% coinsurance for Extended/Specialty Network Providers	Not Covered	Additional cost share may apply for allergy shots & some other procedures
	Preventive care/screening/ immunization	No Charge. Available in Local Network only	Not Covered	You may have to pay for preventive services ordered outside of the accepted standard of care. A precertification requirement may apply.
If you have a test	Diagnostic test (x-ray, blood work)	Local Network: $0 Hospital-based lab services & X-ray 10% coinsurance. $35 X-ray other network provider. Extended/Specialty Network: 25% coinsurance	Not covered	Additional cost share may apply towards auxiliary provider fees: 10% coinsurance/Local Network provider fees 25% coinsurance/Extended Specialty Network Provider fees
	Imaging (CT/PET scans, MRIs)	Local Network: $150 Extended/Specialty Network: 25% coinsurance	Not covered	Precertification may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myvhn.com	Generic drugs	$7 for Preferred $15 or $20 for Non-Preferred	Not covered	Non-preferred cost based on pharmacy choice within Network. Restricted to formulary drugs.
	Preferred brand drugs	$37 or $42	Not covered	Cost based on pharmacy choice within Network. Restricted to formulary drugs.
	Non-preferred brand drugs	$65 or $70	Not covered	Cost based on pharmacy choice within Network. Restricted to formulary drugs.
	Specialty drugs	20% Coinsurance	Not covered	Available at Halifax Outpatient Pharmacy only. Precertification may be required.
			Not covered	

[* For more information about limitations and exceptions, see the plan or policy document at [www.myvhn.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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% or 25% coinsurance*		*Percentage is dependent upon choice of Local or Extended/Specialty Network utilization. Precertification required for non-emergency outpatient surgical care. Your benefits or services may be denied.
	Physician/surgeon fees	10% or 25% coinsurance*	Not covered	*Percentage is dependent upon choice of Local or Extended/Specialty Network utilization. Precertification Required.
If you need immediate medical attention	Emergency room care	$100	Not covered	If deemed medically necessary. Waived if admitted.
	Emergency medical transportation	10% or 25% coinsurance*	Not covered	*If deemed medically necessary. Percentage is dependent upon choice of Local or Extended Specialty Network utilization.
	Urgent care	$50	Not covered	Local Network only
If you have a hospital stay	Facility fee (e.g., hospital room)	$100/day, $500 cap or 25% Coinsurance	Not covered	Cost sharing portion is dependent upon choice of Local or Extended/Specialty Network utilization. Precertification required.
	Physician/surgeon fees	10% or 25% coinsurance*	Not covered	*Percentage is dependent upon choice of Local or Extended/Specialty Network utilization. Precertification required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$45 or 25% coinsurance	Not covered	Individual or group visit only. Cost sharing portion is dependent upon Local or Extended/Specialty Network utilization.
	Inpatient services	$100/day, $500 cap or 25% Coinsurance	Not covered	Cost sharing portion is dependent upon choice of Local or Extended/Specialty Network utilization. Precertification required.
If you are pregnant	Office visits	$45 or 25% coinsurance	Not covered	N/A
	Childbirth/delivery professional services	10% or 25% coinsurance*	Not covered	Precertification required for non-emergency admissions. Your benefits/services may be denied. *Cost sharing portion is depends upon choice of Local or Extended/Specialty Network utilization.
			Not covered	Precertification required. Your services may be denied. Cost sharing portion is dependent

[* For more information about limitations and exceptions, see the plan or policy document at [www.myvhn.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)	
	Childbirth/delivery facility services	$100/day, $500 cap per confinement or 25% coinsurance		upon choice of Local or Extended/Specialty Network utilization.
If you need help recovering or have other special health needs	Home health care	10% or 25% coinsurance*	Not covered	*Percentage is dependent upon choice of Local or Extended/Specialty Network utilization. Precertification required .Your services may be denied. Limited to 44 visits per calendar year.
	Rehabilitation services	10% or 25% coinsurance*	Not Covered	Precertification required. Outpatient limited to 24 visits per calendar year. Includes Physical, Speech, Occupational and Behavior Therapy. *Percentage depends upon choice of Local or Extended/Specialty Network utilization.
	Habilitation services	Orthotics - $100 or 25% coinsurance. Prosthetics- 10% or 25% coinsurance*	Not covered	Precertification required if item is over $300. *Cost sharing portion is dependent upon choice of Local or Extended/Specialty Network utilization.
	Skilled nursing care	10% or 25% coinsurance*	Not covered	*Percentage is dependent upon choice of Local or Extended/Specialty Network utilization. Limited to 90 visits per calendar year. Precertification is required.
	Durable medical equipment	10% or 25% coinsurance*	Not covered	*Percentage is dependent upon choice of Local or Extended/Specialty Network utilization. Precertification required if item is over $300.
	Hospice services	10% or 25% coinsurance*	Not covered	*Percentage is dependent upon choice of Local or Extended/Specialty Network utilization.
If your child needs dental or eye care	Children's eye exam	$0 – Covered in full	Not covered	Included in Network provider Well Child visit
	Children's glasses	Not covered	Not covered	N/A
	Children's dental check-up	50% of covered expenses after $250	Not covered	If Dental Coverage is elected. See Summary Plan Description for additional information.

[* For more information about limitations and exceptions, see the plan or policy document at [www.myvhn.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.)

- Acupuncture
- Cosmetic Surgery
- Hearing Aids
- Long-term care
- Marriage/Family Counseling
- Massage Therapy
- Non-emergency care when traveling outside the United States
- Out-of-network service
- Private Duty Nursing
- Routine Eye Care (Adult)

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

- Bariatric Surgery (Roux-en-Y & gastric sleeve)
- Cardiac Rehabilitation
- Diabetic Education (Hospital based Local Network only)
- Emergency care deemed medically necessary
- Emergency care when traveling outside the United states
- Smoking Cessation (Quick Smart only)
- Weight loss programs (Lighter Lifestyles @ Halifax Health 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: Volusia Health Network at P.O. Box 2814, Daytona Beach, FL 32120].

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 1.877.746.4674
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.877.746.4674
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1.877.746.4674
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1.877.746.4674

———————————*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.myvhn.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	$500
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$500
Copayments	$880
Coinsurance	$900
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$2,340

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$500
Copayments	$1,620
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,680

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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	$500
Copayments	$140
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$740

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