**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 1-844-792-4159. 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.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-new.pdf or call 1-901-843-3750 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | PPO Network providers:<br>$900 / individual or $2,700 / family.<br>Non-PPO Network providers:<br>$1,200 / individual or $3,600 / 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 deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. PPO Network provider preventive care, PPO outpatient hospital diagnostic lab, x-ray, MRI, PET or CT scans are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| **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?** | PPO Network providers:<br>$3,500 per person.<br>Non-PPO Network providers:<br>Not Applicable | The out-of-pocket limit is the most you could pay in a year for covered services. |
| **What is not included in the out-of-pocket limit?** | All plan copayments and deductible, 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 https://myhealth.healthsmart.com or www.multiplan.com 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 |
|---|---|---|---|---|
| | | 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% coinsurance | 50% coinsurance | Teladoc (telephone or web-based video consultations): $5 copay. Call 1-800-835-2362 or visit www.teladoc.com. |
| | Specialist visit | 20% coinsurance | 50% coinsurance | ----------none---------- |
| | Preventive care/screening/ immunization | No charge | 50% coinsurance | 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. Some services may not be covered. Call 1-844-792-4159 for information about limitations. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance (deductible waived for outpatient hospital) | 50% coinsurance | Outpatient services received at Baptist Memorial Hospital or St. Francis Hospital – 0% coinsurance (PPO deductible applies). |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance (deductible waived for outpatient hospital) | 50% coinsurance | |

| 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 drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available from HealthSmart Rx at 1-800-681-6912 or www.healthsmart.com | Generic drugs | $10 copay/retail (30 day supply)<br>$20 copay/retail or mail order (90 day supply) | Not covered | Covers up to a 90-day supply (retail or mail order prescriptions).<br><br>Copay amounts are per prescription.<br><br>If the Physician specifies that a Brand name drug is required, the member will pay the Brand copay. If the member requests a Brand name drug, the individual will be required to pay the Brand copay plus the difference in cost between the Generic and Brand name drugs. (Applies to both retail and mail order prescriptions.) |
| | Preferred brand drugs | $30 copay/retail (30 day supply)<br>$60 copay/retail or mail order (90 day supply) | Not covered | |
| | Non-preferred brand drugs | $45 or 50% (whichever is greater) copay/retail (30 day supply)<br>$90 copay/retail or mail order (90 day supply) | Not covered | |
| | Specialty drugs | Please refer to above copay schedule. Limited to a 30 day supply per fill.<br><br>Copay amounts may differ for drugs subject to the Copay Maximizer Program** | Not covered | Specialty drugs are limited to a 30 day supply per fill and may require prior authorization, call HealthSmart Rx at 1-800-681-6912.<br><br>**This plan has implemented the Copay Maximizer Program in order to utilize financial rebates, discounts and/or assistance programs offered by third-party specialty drug manufacturers. The plan has imposed special utilization requirements for certain specialty drugs. The list of specialty drugs subject to this program can be found here: https://myhealth.healthsmart.com/Login.aspx?ReturnUrl=%2fsecure%2fDefault.aspx<br><br>For more information about the Copay Maximizer Program, please call HealthSmart Rx at 1-800-681-6912. |

| 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) | 20% coinsurance | 50% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of eligible charges (up to $500). Baptist Memorial Hospital or St. Francis Hospital - 0% coinsurance (PPO deductible applies). |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | ----------none---------- |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 50% coinsurance | Baptist Memorial Hospital, St. Francis Hospital, or Methodist Hospital - 0% coinsurance (PPO deductible applies). |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | ----------none---------- |
| | Urgent care | 20% coinsurance | 50% coinsurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of eligible charges (up to $500). Baptist Memorial Hospital or St. Francis Hospital - 0% coinsurance (PPO deductible applies). |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | ----------none---------- |

| 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 mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 50% coinsurance | Teladoc (telephone or web-based video consultations) call 1-800-835-2362 or visit www.teladoc.com.<br>Teladoc behavioral health consultations: Psychiatrist initial visit $30 copay; Psychiatrist recurring visit $30 copay; Psychologist, counselor or therapist visit $30 copay. |
| | Inpatient services | 20% coinsurance | 50% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of eligible charges (up to $500). |
| **If you are pregnant** | Office visits | 20% coinsurance | 50% coinsurance | Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pregnancy expenses for dependent children are not covered. |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | ----------none---------- |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | ----------none---------- |
| | Habilitation services | Not covered | Not covered | Not covered. |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of eligible charges (up to $500). Limited to 100 days per calendar year.<br>Services received at Baptist Memorial Hospital or St. Francis Hospital - 0% coinsurance (PPO 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) | |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. |
| | Hospice services | 20% coinsurance | 50% coinsurance | ----------none---------- |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | ----------none---------- |
| | Children's glasses | Not covered | Not covered | ----------none---------- |
| | Children's dental check-up | Not covered | Not covered | ----------none---------- |

## 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
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss program

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

- Bariatric surgery approved by the Plan
- Chiropractic care

## 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 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: 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 1-1-844-792-4159.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-1-844-792-4159.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-1-844-792-4159.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-1-844-792-4159.

*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 | $900 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $900 |
| Copayments | $0 |
| Coinsurance | $2,340 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,300** |

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

| | |
|---|---|
| The plan's overall deductible | $900 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $900 |
| Copayments | $520 |
| Coinsurance | $200 |
| *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 | $900 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $900 |
| Copayments | $0 |
| Coinsurance | $390 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,290** |

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