
 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 <a href="#">deductible</a> ?	PPO Network providers: \$900 / individual or \$2,700 / family. Non-PPO Network providers: \$1,200 / individual or \$3,600 / family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. PPO Network provider <a href="#">preventive care</a> , PPO outpatient hospital diagnostic lab, x-ray, MRI, PET or CT scans are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	PPO Network providers: \$3,500 per person. Non-PPO Network providers: Not Applicable	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	All plan <a href="#">copayments</a> and <a href="#">deductible</a> , <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://myhealth.healthsmart.com">https://myhealth.healthsmart.com</a> or <a href="http://www.multiplan.com">www.multiplan.com</a> for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Teladoc (telephone or web-based video consultations): \$5 <a href="#">copay</a> . Call 1-800-835-2362 or visit <a href="http://www.teladoc.com">www.teladoc.com</a> .
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. Some services may not be covered. Call 1-844-792-4159 for information about limitations.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> ( <a href="#">deductible</a> waived for outpatient hospital)	50% <a href="#">coinsurance</a>	Outpatient services received at Baptist Memorial Hospital or St. Francis Hospital – 0% <a href="#">coinsurance</a> (PPO <a href="#">deductible</a> applies).
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> ( <a href="#">deductible</a> waived for outpatient hospital)	50% <a href="#">coinsurance</a>	

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

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of eligible charges (up to \$500). Baptist Memorial Hospital or St. Francis Hospital - 0% <a href="#">coinsurance</a> (PPO <a href="#">deductible</a> applies).
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Baptist Memorial Hospital, St. Francis Hospital, or Methodist Hospital - 0% <a href="#">coinsurance</a> (PPO <a href="#">deductible</a> applies).
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of eligible charges (up to \$500). Baptist Memorial Hospital or St. Francis Hospital - 0% <a href="#">coinsurance</a> (PPO <a href="#">deductible</a> applies).
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Teladoc (telephone or web-based video consultations) call 1-800-835-2362 or visit <a href="http://www.teladoc.com">www.teladoc.com</a> . Teladoc behavioral health consultations: Psychiatrist initial visit \$30 <a href="#">copay</a> ; Psychiatrist recurring visit \$30 <a href="#">copay</a> ; Psychologist, counselor or therapist visit \$30 <a href="#">copay</a> .
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of eligible charges (up to \$500).
<b>If you are pregnant</b>	Office visits	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Depending on the type of services, <a href="#">coinsurance</a> or <a href="#">deductible</a> 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% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Habilitation services</a>	Not covered	Not covered	Not covered.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 50% of eligible charges (up to \$500). Limited to 100 days per calendar year. Services received at Baptist Memorial Hospital or St. Francis Hospital - 0% <a href="#">coinsurance</a> (PPO <a href="#">deductible</a> 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)	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----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](#).)

- |   |   |  |
|---|---|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care</li> <li>• Habilitation services</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care</li> <li>• Routine foot care</li> <li>• Weight loss program</li> </ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

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|--|---|
| <ul style="list-style-type: none"> <li>• Bariatric surgery approved by the Plan</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul> |
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### 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](http://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](http://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](http://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, kwijigo holne' 1-1-844-792-4159.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,340
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,300</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$520
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,680</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$390
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,290</b>