
 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 HealthSCOPE Benefits at [www.healthscopebenefits.com](http://www.healthscopebenefits.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 [www.cciio.cms.gov](http://www.cciio.cms.gov) or call your employer at 1-800-458-1060 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$500 person / \$750 employee plus one/ \$1,000 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> ?	Preventative, office visits and, prenatal.	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. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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> ?	Yes. \$2,000 person / \$3,750 employee plus one / \$5,500 family ( <a href="#">deductible</a> & <a href="#">coinsurance</a> ); \$6,350 person / \$12,700 employee plus one or family ( <a href="#">deductible</a> , <a href="#">coinsurance</a> & <a href="#">copays</a> )	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, precertification penalty amounts, balance-billed charges and <a href="#">excluded services</a> .	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> ?	No	This <a href="#">plan</a> pays the same for <a href="#">network</a> or <a href="#">out-of-network providers</a> . 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 or Out-of-Network Provider (You will pay the least)	
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="#">copay</a> /visit	<a href="#">Copay</a> applies per visit regardless of what services are rendered.
	<a href="#">Specialist</a> visit	\$35 <a href="#">copay</a> /visit	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	None
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	None
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.MedBen.com">www.MedBen.com</a> .	Generic drugs	\$10 <a href="#">copay</a> (retail)/ \$30 <a href="#">copay</a> (mail order)	If you choose a preferred or non-preferred drug when a generic equivalent is available, you are responsible for the cost difference between generic & preferred/non-preferred. No <a href="#">copay</a> or <a href="#">deductible</a> for preventive drugs.
	Preferred brand drugs	\$25 <a href="#">copay</a> (retail)/ \$75 <a href="#">copay</a> (mail order)	
	Non-preferred brand drugs	\$50 <a href="#">copay</a> (retail)/ \$150 <a href="#">copay</a> (mail order)	
	<a href="#">Specialty drugs</a>	Paid the same as generic, preferred and non-preferred drugs	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /visit	<a href="#">Copay</a> waived if admitted to hospital.
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	<a href="#">Precertification</a> required for non-medical emergency. Failure to precertify will result in a \$250 penalty.
	<a href="#">Urgent care</a>	\$75 <a href="#">copay</a> /visit	<a href="#">Copay</a> applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <a href="#">copay</a> /visit	<a href="#">Precertification</a> required. Failure to precertify will result in a \$250 penalty.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the plan or policy document at [www.healthscopebenefits.com](http://www.healthscopebenefits.com).

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
		Network or Out-of-Network Provider (You will pay the least)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$250 <a href="#">copay</a>	<a href="#">Deductible</a> does not apply to participating <a href="#">provider</a> office visits.
	Inpatient services	\$500 <a href="#">copay</a>	<a href="#">Precertification</a> required. Failure to precertify will result in a \$250 penalty.
If you are pregnant	Office visits	\$20 <a href="#">copay</a> initial visit, then No Charge	There is no charge and the <a href="#">deductible</a> does not apply to preventive prenatal care and certain breastfeeding support and supplies from a participating provider.
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$500 <a href="#">copay</a> ; \$250 <a href="#">copay</a> birthing center	<a href="#">Precertification</a> required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). Failure to precertify will result in a \$250 penalty. Baby does not count toward the mother's expense; therefore the family <a href="#">deductible</a> amount may apply.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	<a href="#">Precertification</a> required. Failure to precertify will result in a \$250 penalty. Limited to 60 days per year.
	<a href="#">Rehabilitation services</a>	\$35 <a href="#">copay</a> /visit	Includes physical, speech, occupational & cognitive therapy. <a href="#">Deductible</a> does not apply to participating <a href="#">providers</a> . Limited to 60 visits per year for all therapies (combined with chiropractic and pulmonary therapy).
	<a href="#">Habilitation services</a>	Not Covered	
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	Limited to 60 days per year. <a href="#">Precertification</a> required. Failure to precertify will result in a \$250 penalty.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	Includes bereavement counseling. <a href="#">Precertification</a> required. Failure to precertify will result in a \$250 penalty.
If your child needs dental or eye care	Children's eye exam	Not Covered	1 preventative eye exam per year is available under the preventative benefit.
	Children's glasses	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered

\* For more information about limitations and exceptions, see the plan or policy document at [www.healthscopebenefits.com](http://www.healthscopebenefits.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
- Dental Care (Adult & Child)
- 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
- Weight Loss Programs

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

- Bariatric Surgery (for the treatment of morbid obesity only)
- Chiropractic Care
- Hearing Aids (up to age 18)

**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: Tennessee Department of Commerce and Insurance at (800) 342-4029 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272. 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: HealthSCOPE Benefits at 1-800-458-1060.

### 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 1-800-458-1060.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-458-1060.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-458-1060.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-458-1060.

—————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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$580
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,140</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$865
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,420</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">copayment</a>	\$500
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$245
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$ 745</b>