




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. 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 or call your employer at 1-800-458-1060 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Column Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Preventative, office visits, prenatal, and ER visits.	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	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$2,000 person / \$3,750 employee plus one / \$5,500 family (medical copays); \$6,350 person / \$12,700 employee plus one or family (medical and Rx copays)	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 own 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, precertification penalty amounts, balance-billed charges and excluded 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 ?	No	This plan pays the same for network or out-of-network providers . 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 or Out-of-Network Provider (You will pay the least)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay /visit	Copay applies per visit regardless of what services are rendered.
	Specialist visit	\$35 copay /visit	
	Preventive care/screening/immunization	No Charge	None
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	None
	Imaging (CT/PET scans, MRIs)	\$250 copay MRI/ PET; \$150 copay CT	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MedBen.com .	Generic drugs	\$10 copay (retail)/ \$30 copay (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 copay or deductible for preventive drugs.
	Preferred brand drugs	\$25 copay (retail)/ \$75 copay (mail order)	
	Non-preferred brand drugs	\$50 copay (retail)/ \$150 copay (mail order)	
	Specialty drugs	Paid the same as generic, preferred and non-preferred drugs	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 copay	None
	Physician/surgeon fees	0% coinsurance	
If you need immediate medical attention	Emergency room care	\$150 copay /visit	Copay waived if admitted to hospital.
	Emergency medical transportation	\$50 copay	Precertification required for non-medical emergency. Failure to precertify will result in a \$250 penalty.
	Urgent care	\$40 copay /visit	Copay applies per visit regardless of what services are rendered.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay /visit	Precertification required. Failure to precertify will result in a \$250 penalty.
	Physician/surgeon fees	0% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at 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 copay	None
	Inpatient services	\$500 copay	Precertification required. Failure to precertify will result in a \$250 penalty.
If you are pregnant	Office visits	\$25 copay initial visit, then No Charge	There is no charge for preventive prenatal care and certain breastfeeding support and supplies from a participating provider.
	Childbirth/delivery professional services	0% coinsurance	
	Childbirth/delivery facility services	\$500 copay ; \$250 copay birthing center	Precertification 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 deductible amount may apply.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Precertification required. Failure to precertify will result in a \$250 penalty. Limited to 60 days per year.
	Rehabilitation services	\$35 copay /visit	Includes physical, speech, occupational & cognitive therapy. Limited to 60 visits per year for all therapies (combined with chiropractic and pulmonary therapy).
	Habilitation services	Not Covered	This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.
	Skilled nursing care	\$500 copay per admission; \$100 copay if extended care facility	Limited to 60 days per year. Precertification required. Failure to precertify will result in a \$250 penalty.
	Durable medical equipment	\$50 copay	None
	Hospice services	0% coinsurance	Includes bereavement counseling. Precertification 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.

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 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 [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$35
- Hospital (facility) [copayment](#) \$500
- 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$2,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,060

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 copayment](#) \$35
- Hospital (facility) [copayment](#) \$500
- 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$865
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$920

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$35
- Hospital (facility) [copayment](#) \$500
- 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	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$395
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$395