**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, www.webtpa.com/baptist-health.
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.webtpa.com or call 1-855-318-0376 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $3,000 Individual / $6,000 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. Preventive services by a network provider and **prescription drugs** 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. 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. | There are no other specific deductibles. |
| **What is the out-of-pocket limit for this plan?** | $6,750 Individual / $13,500 Family | 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, the overall family out-of-pocket limits must be met. |
| **What is not included in the out-of-pocket limit?** | Penalties, 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 www.webtpa.com/baptist-health or call 1-855-318-0376 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. There is no coverage for out-of-network provider services. 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 |
|---|---|---|---|---|---|---|
| | | Baptist Health Facility (You will pay the least) | Baptist Health Physicians | Cigna Network | OON | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Not Available | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | None |
| | Specialist visit | Not Available | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | None |
| | Preventive care/screening/ immunization | No charge; Deductible Waived | No charge; Deductible Waived | No charge; Deductible Waived | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Coverage requires prior authorization. |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | |

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

| Common Medical Event | Services You May Need | What You Will Pay | | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|---|
| | | Baptist Health Facility (You will pay the least) | Baptist Health Physicians | Cigna Network | OON | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.Navitus.com. | Generic drugs/Tier 1 | Not Available | $15 Copay | Not Covered | Not Covered | Deductible applies. Per 30 day supply. A 90 day supply is available through mail order for 2 copays. |
| | Preferred brand drugs/Tier2 | Not Available | 20% Coinsurance to max of $75 | Not Covered | Not Covered | |
| | Non-preferred brand drugs / Tier 3 | Not Available | 30% Coinsurance to max of $200 | Not Covered | Not Covered | |
| | Specialty drugs | Not Available | 30% Coinsurance to max of $200 | Not Covered | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $100 Copay after Deductible | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | None |
| | Physician/surgeon fees | Not Applicable | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | None |
| **If you need immediate medical attention** | Emergency room care | $250 Copay – First Visit<br>$300 Copay – Second Visit<br>$350 Copay – All Visits after Second Visit | $250 Copay – First Visit<br>$300 Copay – Second Visit<br>$350 Copay – All Visits after Second Visit | $250 Copay – First Visit<br>$300 Copay – Second Visit<br>$350 Copay – All Visits after Second Visit | $250 Copay – First Visit<br>$300 Copay – Second Visit<br>$350 Copay – All Visits after Second Visit after deductible | None |

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

| Common Medical Event | Services You May Need | What You Will Pay | | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|---|
| | | Baptist Health Facility (You will pay the least) | Baptist Health Physicians | Cigna Network | OON | |
| | | | | | of QPA paid @ network benefit level. | |
| | Emergency medical transportation | Not Available | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible Air - 20% Coinsurance after Deductible of QPA paid@ network benefit level. | |
| | Urgent care | $50 Copay after Deductible | $50 Copay after Deductible | $50 Copay after Deductible | Not Covered | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $150 Copay after Deductible | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Coverage requires prior authorization. |
| | Physician/surgeon fees | Not Applicable | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Coverage requires prior authorization. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Not Available | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Coverage requires prior authorization. |
| | Inpatient services | $150 Copay after Deductible | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | |
| **If you are pregnant** | Office visits | Not Available | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Cost sharing does not apply to certain preventive services. Depending on the type of services, [copayment, |
| | Childbirth/delivery professional services | Not Applicable | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | |

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

| Common Medical Event | Services You May Need | What You Will Pay | | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|---|
| | | Baptist Health Facility (You will pay the least) | Baptist Health Physicians | Cigna Network | OON | |
| | Childbirth/delivery facility services | $150 Copay after Deductible | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | coinsurance , or deductible] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| **If you need help recovering or have other special health needs** | Home health care | Not Available | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | 50 Maximum visits per participant per calendar year |
| | Rehabilitation services | $25 Copay after Deductible | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Limited to 90 aggregate therapy visits per participant per calendar year. |
| | Habilitation services | Not Covered | Not Covered | Not Covered | Not Covered | |
| | Skilled nursing care | Not Available | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Limited to 100 days per participant per calendar year. Coverage requires prior authorization. |
| | Durable medical equipment | Not Available | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Coverage requires prior authorization. |
| | Hospice services | Not Available | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Coverage requires prior authorization. |
| **If your child needs dental or eye care** | Children's eye exam | Not Available | No charge; Deductible Waived | No charge; Deductible Waived | Not Covered | Limited to 1 exam per plan year. |
| | Children's glasses | Not Covered | Not Covered | Not Covered | Not Covered | None |
| | Children's dental check-up | Not Covered | Not Covered | Not Covered | Not Covered | None |

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.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
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term Custodial Care
- Private duty nursing
- Routine foot care
- Birthing Center/Home Delivery
- Biofeedback

Bereavement
Non-emergency care when traveling outside the U.S

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

- Bariatric surgery
- Rehabilitation
- Residential Treatment Center
- Chiropractic care
- Physical/Speech/Occupational Therapy
- Partial Day Treatment
- Routine eye care
- Home Health Care
- Neurologic Rehabilitation

Temporomandibular

**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: U.S. Department of Labor's 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html

**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 1-855-318-0376
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-318-0376
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-318-0376
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-318-0376

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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

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* For more information about limitations and exceptions, see the plan or policy document at [www.insert.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 $3,000**
- **Specialist 20% after deductible**
- **Hospital (facility) $150 after deductible**
- **Other 20% after deductible**

**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 | $700 |
| Copayments | $50 |
| Coinsurance | $3,000 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,750** |

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

- **The plan's overall deductible $3,000**
- **Specialist 20% after deductible**
- **Hospital (facility) $150 after deductible**
- **Other 20% after deductible**

**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* | $700 |
| Copayments | $300 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,100** |

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

- **The plan's overall deductible $3,000**
- **Specialist 20% after deductible**
- **Hospital (facility) $150 after deductible**
- **Other 20% after deductible**

**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* | $140 |
| Copayments | $150 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$290** |

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