**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?** | $800 Individual / $1,600 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. 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?** | $9,450 Individual / $18,900 Family | The out-of-pocket limit is the most you could pay in a year for covered pharmacy/ medical 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) | EHN Network | Aetna Network | OON | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Not Available | $25 Copay | $25 Copay | Not Covered | None |
| | Specialist visit | Not Available | $50 Copay + 20% Coinsurance | $50 Copay + 20% Coinsurance | 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) | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | In Office by PCP covered at 100%. |
| | Diagnostic test (labs) | 100% | 100% | 100% | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | $200 Copay All Inclusive | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Precert required if services provided outside of a Baptist-owned facility. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug** | Generic drugs/Tier 1 | $15 Copay | | | | Deductible applies. Per 30-day supply. A 90- day supply is available by mail order for 2 copays. |
| | Preferred brand drugs/Tier2 | 20% Coinsurance to max of $75 | | | | |
| | Non-preferred brand drugs / Tier 3 | 30% Coinsurance to max of $200 | | | | |

* For more information about limitations and exceptions, see the plan or policy document at www.baptist-health.webtpa.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) | EHN Network | Aetna Network | OON | |
| coverage is available at www.Navitus.com. | Specialty drugs | 30% Coinsurance to max of $200 | | | | Specialty Drugs: Filled at Baptist Health Medical Towers Drug Store. Annual visit with Baptist Health Chronic Care Management Clinic required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $500 Copay All Inclusive | 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 | 1st Visit: $300 all-inclusive Copay 2nd Visit: $400 all-inclusive Copay 3rd Visit+: $500 all-inclusive Copay | $400 Copay after Deductible | $400 Copay after Deductible | $400 Copay after Deductible of QPA* paid at network benefit level | None |
| | Emergency medical transportation | 20% Coinsurance after Deductible | | | 20% Coinsurance after Deductible Air - 20% Coinsurance after Deductible of QPA paid@ network benefit level. | |

* For more information about limitations and exceptions, see the plan or policy document at www.baptist-health.webtpa.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) | EHN Network | Aetna Network | OON | |
| | Urgent care | $50 Copay | $50 Copay | $75 Copay | Not Covered | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $950 Copay All Inclusive | 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 | $25 Copay | $25 Copay | Not Covered | None |
| | Inpatient services | $950 Copay All inclusive | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Coverage requires prior authorization. |
| **If you are pregnant** | Office visits | Not Available | $50 Copay then 20% Coinsurance | $50 Copay then 20% Coinsurance | Not Covered | Cost sharing does not apply to certain preventive services. Depending on the type of services, [copayment, coinsurance , or deductible] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | Not Applicable | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | |
| | Childbirth/delivery facility services | $950 Copay All Inclusive | 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.baptist-health.webtpa.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) | EHN Network | Aetna Network | OON | |
| **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 | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Medical necessity review after 12 visits. Limited to 90 aggregate therapy visits per participant per calendar year. Ages 13 and over will only have benefits for therapy done at Baptist. |
| | Habilitation services | $25 Copay | 20% Coinsurance after Deductible | 30% Coinsurance after Deductible | Not Covered | Habilitation services are only covered for ages 12 year and under. Medical necessity review after 12 visits. Limited to 90 aggregate therapy visits per participant per calendar year. |
| | 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% | 30% | Not Covered | Coverage requires prior |

* For more information about limitations and exceptions, see the plan or policy document at www.baptist-health.webtpa.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) | EHN Network | Aetna Network | OON | |
| | | | Coinsurance after Deductible | Coinsurance after Deductible | | 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 |

## 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
- Bereavement
- Hearing aids
- Infertility treatment
- Long-term Custodial Care
- Non-emergency care when traveling outside the U.S
- Private duty nursing
- Routine foot care
- Birthing Center/Home Delivery
- Biofeedback

**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
- Temporomandibular
- Chiropractic care
- Physical/Speech/Occupational Therapy
- Partial Day Treatment
- Routine eye care
- Home Health Care
- Neurologic Rehabilitation

**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

* For more information about limitations and exceptions, see the plan or policy document at www.baptist-health.webtpa.com.

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

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

* For more information about limitations and exceptions, see the plan or policy document at www.baptist-health.webtpa.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 $800**
- **Specialist $50 copay and 20% coinsurance**
- **Hospital (facility) $950 all inclusive**
- **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** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $800 |
| Copayments | $1000 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,260** |

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

- **The plan's overall deductible $800**
- **Specialist $50 copay and 20% coinsurance**
- **Hospital (facility) $950 all inclusive**
- **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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $800 |
| Copayments | $3000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3,820** |

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

- **The plan's overall deductible $800**
- **Specialist $50 copay and 20% coinsurance**
- **Hospital (facility) $950 all inclusive**
- **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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $800 |
| Copayments | $600 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,500** |

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