
 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.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.healthcare.gov/sbc-glossary or call 800-592-3943 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$6,350 Employee, \$12,700 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 Care is 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?	Yes.	You do have to meet deductibles for specific services. There is a \$250/single or \$500/family for Prescription Drugs. The deductible is waived for generic medications.
What is the out-of-pocket limit for this plan ?	\$7,150 Employee, \$14,300 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 , 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, penalties, amounts over Usual and Customary fees and excluded charges.	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 does not use a provider network .
Do you need a referral to see a specialist ?	No. You don't need a referral to see a specialist .	You can see the specialist you choose without a referral .

Benefit	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Gold VBP	\$36	\$235	\$125	\$340
Silver VBP	N/A	\$207	\$107	\$282
Bronze VBP	N/A	\$73	\$64	\$100
UHC Gold Plan	\$100	\$250	\$155	\$400

 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	40% coinsurance	None
	Specialist visit	40% coinsurance	
	Preventive care/screening/immunization	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.southernscripts.net	Generic drugs	1-30 day: \$15 copay 31-60 day: \$30 copay 61-90 day: \$45 copay	\$250/single or \$500/family for Prescription Drugs. Deductible waived for generic medications.
	Preferred brand drugs	1-30 day: \$30 copay 31-60 day: \$60 copay 61-90 day: \$90 copay	
	Non-preferred brand drugs	1-30 day: \$60 copay 31-60 day: \$120 copay 61-90 day: \$180 copay	
	Specialty drugs	30% coinsurance Maximum of \$500	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Precertification is required
	Physician/surgeon fees	40% coinsurance	None
If you need immediate medical attention	Emergency room care	40% coinsurance	None
	Emergency medical transportation	40% coinsurance	None
	Urgent care	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Precertification is required
	Physician/surgeon fees	40% coinsurance	None

* 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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% coinsurance	None
	Inpatient services	40% coinsurance	Precertification is required
If you are pregnant	Office visits	40% coinsurance	There is no charge and the deductible does not apply to preventive prenatal care and certain breastfeeding support and supplies from a participating provider.
	Childbirth/delivery professional services	40% coinsurance	
	Childbirth/delivery facility services	40% coinsurance	Precertification is required for inpatient Hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section).
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Precertification is required
	Rehabilitation services	40% coinsurance	Occupational, Physical, and Speech therapy are each limited to 20 visits per year.
	Habilitation services	40% coinsurance	
	Skilled nursing care	40% coinsurance	Precertification is required. Limited to 100 visits per calendar year.
	Durable medical equipment	40% coinsurance	Precertification is required
	Hospice services	No Charge	Precertification is required
If your child needs dental or eye care	Children's eye exam	Children under the age of six: No Charge Over the age of six: 40% coinsurance	None
	Children's glasses	Not Covered	None
	Children's dental check-up	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](#).)

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|---------------------|--|------------------------|
| • Bariatric Surgery | • Infertility Treatment | • Routine Foot Care |
| • Cosmetic Surgery | • Long Term Care | • Weight Loss Programs |
| • Dental Care | • Non-emergency care when traveling outside the U.S. | |
| | • Private Duty Nursing | |

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

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| • Acupuncture | • Routine eye care (Adult) (one per year) |
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- Chiropractic Care
- Hearing Aids

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: 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 800-592-3943.

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 800-592-3943.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-592-3943.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 800-592-3943.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-592-3943.

—————*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	\$6,350
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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	\$2,190
Copayments	\$0
Coinsurance	\$4,960
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$7,210

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$6,350
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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	\$1,756
Copayments	\$855
Coinsurance	\$1,170
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$3,836

Mia's Simple Fracture

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

■ The plan's overall deductible	\$6,350
■ Specialist coinsurance	40%
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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	\$821
Copayments	\$0
Coinsurance	\$547
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,368