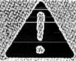

All copayment and coinsurance costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay per visit, deductible does not apply	50% coinsurance	Virtual visits (Telehealth) - No Charge by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery. Children under age 19: No Charge.
	Specialist visit	$80 copay per visit, deductible does not apply	50% coinsurance	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Includes preventive health services specified in the health care reform law. 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)	Designated Network Lab: $15 copay per service, deductible does not apply X-ray: $75 copay per service, deductible does not apply .	50% coinsurance	If services performed in outpatient hospital setting, deductible/coinsurance may apply. Preauthorization required for out-of-Network for certain services or benefit reduces to the lesser of 50% or $2,500. For Designated Network Benefits, lab services must be received by a Designated Diagnostic Provider. Network Benefits are lab services received from a Network provider that is not a Designated Diagnostic Provider and is covered at 50% coinsurance .
	Imaging (CT/PET scans, MRIs)	Designated Network: 20% coinsurance	50% coinsurance	For Designated Network Benefits, radiation services must be received from a Designated Diagnostic Provider. Network Benefits are services received from a Network provider that is not a Designated Diagnostic Provider and is covered at 40% coinsurance . Preauthorization required for out-of-Network or benefit reduces to the lesser of 50% or $2,500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www. welcometouhc.com	Tier 1 - Your Lowest-Cost Option	Deductible does not apply. Retail: $10 copay Mail-Order: $30 copay Specialty Drugs** : $10 copay	Deductible does not apply. Retail: $10 copay Specialty Drugs: $10 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order*: Up to a 90 day supply or *Preferred 90 Day Retail Network pharmacy. If you use an out-of-Network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. **Your cost shown is for a Preferred Specialty Network Pharmacy and Non-Preferred Specialty Network Pharmacy. Copay is per prescription order up to the day supply limit listed above. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Prescription drug List (PDL): Essential . Network: National. . If a dispensed drug has a chemically equivalent drug, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Certain preventive medications, zero cost share medications, and Tier 1 contraceptives are covered at No Charge. .
	Tier 2 - Your Midrange-Cost Option	Deductible does not apply. Retail: $35 copay Mail-Order: $105 copay Specialty Drugs** : $35 copay	Deductible does not apply. Retail: $35 copay Specialty Drugs: $35 copay	
	Tier 3 - Your Midrange-Cost Option	Deductible does not apply. Retail: $130 copay Mail-Order: $390 copay Specialty Drugs** : $130 copay	Deductible does not apply. Retail: $130 copay Specialty Drugs: $130 copay	
	Tier 4 - Additional High-Cost Options	Deductible does not apply. Retail: $250 copay Mail-Order: $750 copay Specialty Drugs** : $500 copay	Deductible does not apply. Retail: $250 copay Specialty Drugs: $500 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization required for certain services for out-of-Network or benefit reduces to the lesser of 50% or $2,500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copay per visit, deductible does not apply	50% coinsurance	If you receive services in addition to urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network or benefit reduces to the lesser of 50% or $2,500.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay per visit, deductible does not apply	50% coinsurance	Network partial hospitalization/ intensive outpatient treatment: 0% coinsurance Preauthorization required for certain services for out-of-Network or benefit reduces to the lesser of 50% or $2,500.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network or benefit reduces to the lesser of 50% or $2,500.
If you are pregnant	Office visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, deductibles, or coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient preauthorization apply for out-of-Network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to the lesser of 50% or $2,500.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization required for out-of-Network or benefit reduces to the lesser of 50% or $2,500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	$40 copay per outpatient visit, deductible does not apply	50% coinsurance	Limits per calendar year: Physical, Speech, Occupational: 20 visits each; Pulmonary and Cardiac: 36 visits each.
	Habilitation services	$40 copay per outpatient visit, deductible does not apply	50% coinsurance	Limits per calendar year: Physical, Speech, Occupational: 20 visits each. Cost share applies for outpatient services only. Preauthorization required for out-of-Network inpatient services or benefit reduces to the lesser of 50% or $2,500.
	Skilled nursing care	20% coinsurance	50% coinsurance	Skilled Nursing is limited to 60 days per calendar year (combined with Inpatient Rehabilitation). Preauthorization required for out-of-Network or benefit reduces to the lesser of 50% or $2,500.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network Durable medical equipment over $1,000 or no coverage.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network before admission for an Inpatient Stay in a hospice facility or benefit reduces to the lesser of 50% or $2,500.
If your child needs dental or eye care	Children's eye exam	$10 copay per visit, deductible does not apply	50% coinsurance	One exam every 12 months.
	Children's glasses	$25 copay per frame, deductible does not apply	50% coinsurance	One pair every 12 months. Costs may increase depending on the frames selected. You may choose contact lenses instead of eyeglasses. The benefit does not cover both.
	Children's dental check-up	0% coinsurance	50% coinsurance	Cleanings covered 2 times per 12 months. Additional limitations may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	$40 copay per outpatient visit, deductible does not apply	50% coinsurance	Limits per calendar year: Physical, Speech, Occupational: 20 visits each; Pulmonary and Cardiac: 36 visits each.
	Habilitation services	$40 copay per outpatient visit, deductible does not apply	50% coinsurance	Limits per calendar year: Physical, Speech, Occupational: 20 visits each. Cost share applies for outpatient services only. Preauthorization required for out-of-Network inpatient services or benefit reduces to the lesser of 50% or $2,500.
	Skilled nursing care	20% coinsurance	50% coinsurance	Skilled Nursing is limited to 60 days per calendar year (combined with Inpatient Rehabilitation) . Preauthorization required for out-of-Network or benefit reduces to the lesser of 50% or $2,500.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network Durable medical equipment over $1,000 or no coverage.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization required for out-of-Network before admission for an Inpatient Stay in a hospice facility or benefit reduces to the lesser of 50% or $2,500.
If your child needs dental or eye care	Children's eye exam	$10 copay per visit, deductible does not apply	50% coinsurance	One exam every 12 months.
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	Children's dental check-up	0% coinsurance	50% coinsurance	Cleanings covered 2 times per 12 months. Additional limitations may apply.

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	• Bariatric surgery	• Cosmetic surgery	• Dental care (Adult)	• Infertility treatment
• Long-term care	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing	• Routine Eye Care (Adult)	• 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.)	
• 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: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration. You may also contact us at 1-800-782-3740 . 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 on how 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: 1-800-782-3740 ; or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Tennessee Department of Commerce & Insurance at 1-800-342-4029 or www.tn.gov/commerce.

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 1-800-782-3740 .
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740 .
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-782-3740 .
Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-800-782-3740 .

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