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, go to www.yourtpa.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.yourtpa.com or call 1-800-451-4318 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 PPO/person; $6,000 non-PPO/person per plan year - Maximum $3,000 PPO/family; $12,000 Non-PPO/family per plan year. Plan year begins 9/1.	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. PPO hospital outpatient services, facility outpatient surgery services, PPO office visits, diagnostic procedures, hospice, durable medical equipment, Preventative Services, chiropractic services	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	See the Common Medical Events chart below for your costs for services this plan covers.
What is the out-of-pocket limit for this plan?	$7,900 PPO/person; $15,800 PPO/family. Unlimited Non-PPO providers	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 limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services do not count toward the out-of-pocket limit.	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. For PPO providers, see www.employeeservices.me/GroupHealthPlan.aspx or call 850-478-8496 Ext 2789 for PCC Local Providers Network	You pay the least if you use a provider in the Preferred Provider Network. You pay more if you use a provider in the PPO network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
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
		PPO Providers	Non-PPO Providers	
If you visit a health care provider's office or clinic **You may have to pay for services that aren't preventative. Ask your provider if the services needed are preventative. Then check what your plan will pay for.**	Primary care visit to treat an injury or illness	PPO Provider $40/visit copayment PCC Local Providers Network $25/visit copayment Xray and Lab and other office procedures $25/visit copayment. Deductible does not apply.	20% coinsurance; Xray, Lab and other office procedures 20% coinsurance after $80/visit copayment. Deductible does not apply to Xray and Lab and other office procedures	Chiropractic services – maximum allowable charge $40/visit - $25 copayment – services from Non-PPO providers not covered
	Specialist visit	PPO Provider $50/visit copayment PCC Local Providers Network $25/visit copayment Xray and Lab and other office procedures $25/visit copayment Deductible does not apply.	20% coinsurance; Xray and Lab and other office procedures 20% coinsurance after $80/visit copayment. Deductible does not apply to Xray and Lab and other office procedures	None.
	Preventive care/screening/ immunization	No Charge Deductible does not apply.	Not Covered	Limited to services covered under the Affordable Care Act
If you have a test	Diagnostic test (x-ray, blood work)	Hospital testing - $100 copayment. Independent Lab - $25 copayment. Deductible does not apply.	Hospital testing – 20% coinsurance after $300 copayment. Independent Lab 20% coinsurance after $80 copayment. Deductible does not apply to Independent Lab	Non-PPO hospital testing subject to plan year deductible. Non-PPO independent lab plan year deductible does not apply.
	Imaging (CT/PET scans, MRIs)	Independent Facility - $100 copayment. Hospital - $300	Independent Facility - 20% coinsurance after $300 copayment. Hospital testing	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Providers	Non-PPO Providers	
		copayment. Deductible does not apply.	– 20% coinsurance $600 copayment. Deductible does not apply.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com	Generic drugs	$20 copayment retail / $30 copayment mail order	Not covered	Specific over-the-counter ulcer and allergy medications $0 copayment with physician's written RX. Retail limited to 30 day supply, Mail Order limited to 90 day supply
	Preferred brand drugs	50% copayment- $75 maximum retail/50% copayment $150 maximum mail order	Not covered	Retail limited to 30 day supply, Mail Order limited to 90 day supply
	Non-preferred brand drugs	50% copayment- $125 maximum retail/50% copayment $250 maximum mail order	Not covered	Retail limited to 30 day supply, Mail Order limited to 90 day supply
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copayment Deductible does not apply.	20% coinsurance after $300 copayment Deductible does not apply.	Copayment is all inclusive for all charges related to out-patient surgery. Pre-certification required - $500 penalty.
	Physician/surgeon fees	$250 copayment Deductible does not apply.	20% coinsurance after $300 copayment Deductible does not apply.	Copayment is all inclusive for all charges related to out-patient surgery. Pre-certification required - $500 penalty.
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Deductible applies
	Emergency medical transportation	0% coinsurance	0% coinsurance	Limited to services within 50 miles unless medically necessary. Deductible applies.
	Urgent care	PPO Provider $40/visit copayment PCC Local Providers Network $25/visit copayment	20% coinsurance; Xray, Lab and other office procedures 20% coinsurance after $80/visit copayment. Deductible does not apply to	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Providers	Non-PPO Providers	
		Xray and Lab and other office procedures $25/visit copayment. Deductible does not apply.	Xray and Lab and other office procedures	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment per admission.	20% coinsurance after $500 copayment per admission	Pre-certification required - $500 penalty.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	Outpatient and inpatient surgeries require pre-certification - $500 penalty
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Same as any illness	Same as any illness	Substance abuse excluded service
	Inpatient services	$250 copayment per admission.	20% coinsurance after $500 copayment per admission	Pre-certification required. $500 penalty applies. Substance abuse excluded service.
If you are pregnant	Office visits	Same as any illness	Same as any illness	Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	None.
	Childbirth/delivery facility services	$250 copayment; nursery No charge, deductible does not apply for well baby	20% coinsurance after $500 copayment; nursery 20% coinsurance, deductible does not apply for well baby	Nursery benefit for family plans only
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Limited to 100 visits per plan year
	Rehabilitation services	0% coinsurance	20% coinsurance	None.
	Habilitation services	0% coinsurance	20% coinsurance	None.
	Skilled nursing care	0% coinsurance	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Providers	Non-PPO Providers	
	Durable medical equipment	0% coinsurance up to $1,000; 20% coinsurance after $1,000; deductible does not apply	20% coinsurance; deductible does not apply	Precertification required for purchases over $1000. $500 penalty applies.
	Hospice services	0% coinsurance; deductible does not apply	20% coinsurance; deductible does not apply	None.
If your child needs dental or eye care	Children's eye exam	Excluded service	Excluded service	None.
	Children's glasses	Excluded service	Excluded service	None.
	Children's dental check-up	Excluded service	Excluded service	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 (Adult)
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Substance abuse treatment

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

- Bariatric surgery
- Chiropractic care
- Habilitation services
- Non-emergency care when traveling outside the U.S. – see www.yourtpa.com
- Private-duty nursing
- Weight loss programs – see www.yourtpa.com

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 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: Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 850-478-8496.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 850-478-8496.]

[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 850-478-8496.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 850-478-8496.]

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	$1500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	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	**$12,686**

In this example, Peg would pay:

Cost Sharing	
Deductibles *	$1500
Copayments	$389
Coinsurance	$0
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$1950**

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

The plan's overall deductible	$1500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	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	**$5,601**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1772
Coinsurance	$0
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$1772**

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

The plan's overall deductible	$1500
Specialist *[cost sharing]*	$50
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1500
Copayments	$405
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1905**

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