**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, visit www.BenefitsAccess.org. 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 https://www.healthcare.gov/sbc-glossary or call 1-833-762-0876 to request a copy.

**Benefits are provided by Wespath Benefits and Investments. Medical coverage and behavioral health benefits use the Blue Cross Blue Shield Nationwide PPO network; prescription coverage is managed by OptumRx. For assistance, members should contact their Wespath Care Coordinators at 1-833-762-0876.**

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **If took Health Check:**<br>In-Network: $1,000 individual / $2,000 family<br>Out-of-Network[1]: $2,000 individual / $4,000 family<br><br>**If did not take Health Check:**<br>In-Network: $1,250 individual / $2,500 family<br>Out-of-Network[1]: $2,250 individual / $4,500 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 | 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. $50 individual or $150 family deductible for dental benefits, if elected. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | In-Network: $5,000 individual / $10,000 family<br>Out-of-Network[1]: $10,000 individual / $20,000 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?** | Copayments for certain services, premiums, balance-billing charges, vision expenses, dental expenses, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. Go to www.BenefitsAccess.org, log in and select the Health Menu and click on "Contact Your Care Coordinator" under Mental/Behavioral Health or call 1-833-762-0876 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. You will pay the most if you use an out-of-network provider[1], and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider[1] 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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider[1] (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 | $30 copay / visit | 40% coinsurance after deductible | None. |
| | Specialist visit | $50 copay / visit and 100% coverage for allergy injections | 40% coinsurance after deductible | None. |
| | Preventive care/screening/ immunization | No charge (deductible does not apply) | 40% coinsurance after deductible | 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) | 20% coinsurance after deductible | 40% coinsurance after deductible | None. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 40% coinsurance after deductible | Preauthorization is required for MRI, MRA and PET scans. |

[1] Starting January 1, 2022, as required by applicable law, in-network cost sharing rules may apply for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this SBC.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred 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.BenefitsAccess.org** Select Go to OptumRx under the Health menu. | Generic drugs | **Retail (30-day)** $10 copay | **Retail (30-day)** Copay plus amount exceeding allowed amount | *To maximize plan benefits, **refills for most maintenance medications require use of the OptumRx Home Delivery (mail-order) service or a local Walgreens pharmacy.** Non-sedating allergy drugs are covered as non-preferred. Specialty drugs may require pre-authorization by contacting OptumRx at **1-855-239-8471** |
| | | ***Walgreens or OptumRx Home Delivery (up to 90-day supply)** $25 copay | | |
| | Preferred brand drugs | **Retail (30-day)** 30% coinsurance ($30 minimum; $65 maximum) | **Retail (30-day)** coinsurance plus amount exceeding allowed amount | |
| | | ***Walgreens or OptumRx Home Delivery (up to 90-day supply)** 30% coinsurance ($75 minimum; $165 maximum) | | |
| | Non-preferred brand drugs | **Retail (30-day)** 40% coinsurance ($50 minimum; $120 maximum) | **Retail (30-day)** coinsurance plus amount exceeding allowed amount | |
| | | ***Walgreens or OptumRx Home Delivery (up to 90-day supply)** 40% coinsurance ($125 minimum; $300 maximum) | | |
| | Specialty drugs | coinsurance after deductible, dependent on classification of drug (e.g., preferred, non-preferred) | coinsurance dependent on classification of drug (e.g., preferred, non-preferred) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | 40% coinsurance after deductible | Preauthorization is required. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible | None. |

[1] Starting January 1, 2022, as required by applicable law, in-network cost sharing rules may apply for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this SBC.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred Provider (You will pay the most) | |
| **If you need immediate medical attention**[1] | Emergency room care | $200 copay / visit | $200 copay / visit | Copayment waived if admitted. Costs assume true emergency. |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | Costs assume true emergency. |
| | Urgent care | $100 copay / visit | $100 copay / visit | $100 copay applies if a true emergency. If not a true emergency, as defined in the Plan, the Plan pays 60% after the out-of-network deductible for a out-of-network[1] provider. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | $200 copayment then 40% coinsurance after deductible | Preauthorization is required. |
| | Physician/surgeon fees | 20% coinsurance after deductible | $200 copayment then 40% coinsurance after deductible | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $15 copay / visit | $15 copay / visit | Eligible out-of-pocket expenses for the behavioral health, pharmacy and medical plans count toward the out-of-pocket limit. Preauthorization is required for intensive outpatient services. |
| | Inpatient services | 20% coinsurance after deductible | $200 copayment then 40% coinsurance after deductible | Preauthorization is required, including for partial hospitalization. |
| **If you are pregnant** | Office visits | No charge (deductible does not apply) for prenatal care except ultrasounds 20% coinsurance after deductible for ultrasounds and subsequent eligible physician charges | 40% coinsurance after deductible | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |

[1] Starting January 1, 2022, as required by applicable law, in-network cost sharing rules may apply for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this SBC.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred Provider (You will pay the most) | |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | 40% coinsurance after deductible | |
| | Childbirth/delivery facility services | 20% coinsurance after deductible | 40% coinsurance after deductible | Preauthorization is required. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance after deductible | 40% coinsurance after deductible | Limited to 60 visits per calendar year. Preauthorization is required. |
| | Rehabilitation services | $30 copay / visit | 40% coinsurance after deductible | Benefits reflect outpatient services. Inpatient rehabilitation will be considered under the inpatient hospitalization benefit and require preauthorization. |
| | Habilitation services | $30 copay / visit | 40% coinsurance after deductible | None. |
| | Skilled nursing care | 20% coinsurance after deductible | 40% coinsurance after deductible | Limited to 120 days per calendar year. Preauthorization is required. |
| | Durable medical equipment | 20% coinsurance after deductible | 40% coinsurance after deductible | Coverage for wigs is limited to 5 per lifetime. Preauthorization is required for all rentals and any purchase over $1,500. |
| | Hospice services | 20% coinsurance after deductible | 40% coinsurance after deductible | Preauthorization is required. |
| **If your child needs dental or eye care** | Children's eye exam | **Exam Core:** $20 copay **Full Vision:** $20 copay **Premier Vision:** $20 copay | **Exam Core:** Exam fee exceeding $45 **Full Vision:** Exam fee exceeding $45 **Premier Vision:** Exam fee exceeding $45 | **Exam Core:** Includes one exam every year **Full Vision:** Includes one exam every year **Premier Vision:** Includes one exam every year |

[1] Starting January 1, 2022, as required by applicable law, in-network cost sharing rules may apply for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this SBC.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Provider (You will pay the least) | Nonpreferred Provider (You will pay the most) | |
| | Children's glasses | **Exam Core:** Not Covered **Full Vision:** $20 copay for glasses; cost in excess of $160 for frames **Premier Vision:** $20 copay for glasses; cost in excess of $200 for frames | **Exam Core:** Not Covered **Full Vision:** Cost of frames in excess of $70. Cost of single vision lenses over $30; line bifocal lenses over $50; lined trifocal lenses over $65 **Premier Vision:** Cost of frames in excess of $70. Cost of single vision lenses over $30; line bifocal lenses over $50; lined trifocal lenses over $65 | **Exam Core:** None **Full Vision:** Includes one pair of frames and lenses every year **Premier Vision:** Includes one pair of frames and lenses and contact lenses or two pair of frames and lenses every year |
| | Children's dental check-up | **Dental PPO:** No charge **Dental HMO*:** No charge **Passive PPO 2000:** No charge | **Dental PPO:** No charge **Dental HMO*:** No charge **Passive PPO 2000:** No charge | **Dental PPO:** Annual coverage is limited to $2,000 maximum (in-network) and $1,000 (out-of-network) for all covered services **Dental HMO*:** Please refer to Dental HMO Patient Charge Schedule for additional services. **Passive PPO 2000:** Coverage is limited to $2,000 annual maximum for all covered services |

*Not available in all areas.

## 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.)** | | |
|---|---|---|
| • Cosmetic surgery | • Long-term care | • Non-emergency care when traveling outside the U.S. |

[1] Starting January 1, 2022, as required by applicable law, in-network cost sharing rules may apply for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this SBC.

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture | • Bariatric surgery (if meet eligibility) | • Chiropractic care |
| • Dental care (Adult), if elected | • Hearing aids | • Infertility treatment |
| • Private-duty nursing | • Routine eye care (Adult) | • Routine foot care |
| • Weight loss programs | | |

**Your Rights to Continue Coverage: 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: your Wespath Care Coordinator at 1-833-762-0876 or visit us at www.myWespathHealth.com.

**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 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 1-833-762-0876.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-762-0876.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-762-0876.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-762-0876.

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



[1] Starting January 1, 2022, as required by applicable law, in-network cost sharing rules may apply for certain out-of-network services, including certain emergency services, air ambulance services, and services from an out-of-network provider at an in-network facility. This means the amount you pay for these services may be lower than provided in this SBC.

## 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 | $1,250 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $1,250 |
| Copayments | $10 |
| Coinsurance | $2,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,620** |

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

| | |
|---|---|
| The plan's overall deductible | $1,250 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $1,250 |
| Copayments | $400 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,770** |

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

| | |
|---|---|
| The plan's overall deductible | $1,250 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**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 | $1,250 |
| Copayments | $300 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,750** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: **1-800-851-2201**.

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