**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.integratpa.com or call 1-800-959-3518. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.integratpa.com or call 1-800-959-3518 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For participating providers **$750** person / **$1,500** family | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes, see below for benefits. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copay or coinsurance may apply |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Medical: For participating providers **$1,500** person / **$3,000** family<br>RX: **$1,000** person / **$2,000** 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?** | Non Compliance Pre Cert Penalties | 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 coj.claimsbridge.com for a list of UF Health Direct Care participating providers.<br>. | 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, 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 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 copay 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 | $10 copay/visit | N/A | ---none--- |
| | Specialist visit | $50 copay/visit | N/A | ---none--- |
| | Preventive care/screening/ immunization | No Charge | N/A | ---none--- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | X-Ray: Deductible, 20% coinsurance<br>Lab: No Charge | N/A | ---none--- |
| | Imaging (CT/PET scans, MRIs) | Deductible, 20% coinsurance | N/A | ---none--- |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at www.integratpa.com | Generic drugs | $10 copay/ prescription for 30 Day Supply<br>$20 copay/ prescription for 90 Day Supply | N/A | Maximum OOP: $1,000 Individual. $2,000 Family |
| | Preferred brand drugs | $40 copay/ prescription for 30 Day Supply<br>$80 copay/ prescription for 90 Day Supply | N/A | Maximum OOP: $1,000 Individual. $2,000 Family |
| | Non-preferred brand drugs | $75 copay/ prescription for 30 Day Supply<br>$150 copay/ prescription for 90 Day Supply | N/A | Maximum OOP: $1,000 Individual. $2,000 Family |
| | Specialty drugs | $75 copay/ prescription for 30 Day Supply | N/A | No 90 Day Mail Order. Maximum OOP: $1,000 Individual. $2,000 Family |

[* For more information about limitations and exceptions, see the plan or policy document at www.integratpa.com.]

| 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Deductible, 20% coinsurance | N/A | Pre-authorization required.<br>Failure to pre-authorize will result in a penalty. |
| | Physician/surgeon fees | Deductible, 20% coinsurance | N/A | ---none--- |
| **If you need immediate medical attention** | Emergency room care | Deductible, 20% coinsurance | In Network Deductible, 20% coinsurance | For Non-Emergency Use:<br>50% coinsurance In Network Only. |
| | Emergency medical transportation | Deductible, 20% coinsurance | In Network Deductible, 20% coinsurance | ---none--- |
| | Urgent care | $25 copay/visit | $25 copay/visit | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Deductible, 20% coinsurance | N/A | Semi Private Room.<br>Pre-authorization required.<br>Failure to pre-authorize will result in a penalty. |
| | Physician/surgeon fees | Deductible, 20% coinsurance | N/A | ---none--- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $10 copay/visit | N/A | ---none--- |
| | Inpatient services | Deductible, 20% coinsurance | N/A | ---none--- |
| **If you are pregnant** | Office visits | $10 copay/visit | N/A | ---none--- |
| | Childbirth/delivery professional services | Deductible, 20% coinsurance | N/A | ---none--- |
| | Childbirth/delivery facility services | Deductible, 20% coinsurance | N/A | ---none--- |

[* For more information about limitations and exceptions, see the plan or policy document at www.integratpa.com.]

| 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 help recovering or have other special health needs** | Home health care | Deductible, 20% coinsurance | N/A | Coverage is limited to 100 visits per Plan Year. |
| | Rehabilitation services | Deductible, 20% coinsurance | N/A | Coverage is limited to 100 Days per Plan Year. Failure to pre-authorize will result in a penalty. |
| | Habilitation services | Deductible, 20% coinsurance | N/A | Coverage is limited to 60 visits per Plan Year. |
| | Skilled nursing care | Deductible, 20% coinsurance | N/A | Coverage is limited to 100 Days per Plan Year. |
| | Durable medical equipment | Deductible, 20% coinsurance | N/A | ---none--- |
| | Hospice services | Deductible, 20% coinsurance | N/A | ---none--- |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | N/A | ---none--- |
| | Children's glasses | N/A | N/A | Dental/Vision/Hearing benefits may be available, but are not part of the Medical Plan, therefore are not listed on this SBC |
| | Children's dental check-up | N/A | N/A | Dental/Vision/Hearing benefits may be available, but are not part of the Medical Plan, therefore are not listed on this SBC |

## 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) |
| • Hearing aids | • Infertility treatment | • Long-term care |
| • Non-emergency care when traveling outside the U.S. | • Private-duty nursing | • 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.) | | |
|---|---|---|
| • Bariatric surgery | • Chiropractic care | • Routine eye care (Adult) |

**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: For more information on your rights to continue coverage, contact the plan at 1-800-959-3518. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services 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:** If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Your health plan at 1-800-959-3518, or the Department of Labor's Employee Benefits Security Administration at 1 866 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
Florida: Additionally, a consumer assistance program can help you file your appeal. Contact Florida Department of Financial Services, Division of Consumer Services, 200 East Gaines Street, Tallahassee, FL 32399-4288, (877) 693-5236, http://www.floir.com/consumers. 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**
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 800-959-3518, INTEGRA Customer Service / Language Line.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-959-3518, INTEGRA Customer Service / Language Line.
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 800-959-3518, INTEGRA Customer Service / Language Line.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-959-3518, INTEGRA Customer Service / Language Line.

*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.integratpa.com.]

**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, copays and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different

## Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $750 |
| 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** | **$12,800** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $750 |
| Copays | $0 |
| Coinsurance | $750 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,560** |

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

| | |
|---|---|
| The plan's overall deductible | $750 |
| 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** | **$7,400** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $710 |
| Copays | $613 |
| Coinsurance | $177 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,555** |

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

| | |
|---|---|
| The plan's overall deductible | $750 |
| 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** | **$1,900** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $750 |
| Copays | $150 |
| Coinsurance | $326 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,226** |

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: INTEGRA at 800-959-3518 or go to www.integratpa./com.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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