
 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](http://www.integratpa.com) or call 1-800-959-3518. 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.integratpa.com](http://www.integratpa.com) or call 1-800-959-3518 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For participating <a href="#">providers</a> \$250 person / \$500 family	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, see below for benefits.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical: For participating <a href="#">providers</a> \$1,500 person / \$3,000 family RX: \$1,000 person / \$2,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, Balance-Billed charges, Health Care this plan does not cover and Non Compliance Pre Cert Penalties	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://coj.claimsbridge.com">coj.claimsbridge.com</a> for a list of UF Health Direct Care participating <a href="#">providers</a>	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$10 <a href="#">copayment</a>	N/A	---none---
	<a href="#">Specialist</a> visit	\$30 <a href="#">copayment</a>	N/A	---none---
	<a href="#">Preventive care/screening/immunization</a>	No Charge	N/A	You may have to pay for services that are not <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> .
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-Ray: \$30 <a href="#">copayment</a> Lab: No Charge	N/A	LabCorp or UF Health Hospital Labs
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copayment</a>	N/A	---none---
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.integratpa.com">www.integratpa.com</a>	Generic drugs	\$10 <a href="#">copayment</a> prescription for 30 Day Supply \$20 <a href="#">copayment</a> prescription for 90 Day Supply	N/A	Maximum OOP: \$1,000 Individual. \$2,000 Family
	Preferred brand drugs	\$40 <a href="#">copayment</a> prescription for 30 Day Supply \$80 <a href="#">copayment</a> prescription for 90 Day Supply	N/A	Maximum OOP: \$1,000 Individual. \$2,000 Family
	Non-preferred brand drugs	\$75 <a href="#">copayment</a> prescription for 30 Day Supply \$150 <a href="#">copayment</a> prescription for 90 Day Supply	N/A	Maximum OOP: \$1,000 Individual. \$2,000 Family
	<a href="#">Specialty drugs</a>	\$75 <a href="#">copayment</a> 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](http://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)	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	N/A	<a href="#">Pre-authorization</a> required. Failure to <a href="#">pre-authorize</a> will result in a penalty.
	Physician/surgeon fees	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	N/A	---none---
If you need immediate medical attention	<a href="#">Emergency room care</a>	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	In Network <a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	For Non-Emergency Use: 50% <a href="#">coinsurance</a> In Network Only.
	<a href="#">Emergency medical transportation</a>	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	In Network <a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	---none---
	<a href="#">Urgent care</a>	\$25 <a href="#">copayment</a>	\$25 <a href="#">copayment</a>	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	N/A	Semi Private Room. <a href="#">Pre-authorization</a> required. Failure to <a href="#">pre-authorize</a> will result in a penalty.
	Physician/surgeon fees	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	N/A	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copayment</a>	N/A	---none---
	Inpatient services	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	N/A	<a href="#">Pre-authorization</a> required. Failure to <a href="#">pre-authorize</a> will result in a penalty.
If you are pregnant	Office visits	\$10 <a href="#">copayment</a>	N/A	Routine Pre-Natal and Post-Natal covered under Global Delivery Fee.
	Childbirth/delivery professional services	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	N/A	---none---
	Childbirth/delivery facility services	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	N/A	---none---

[\* For more information about limitations and exceptions, see the plan or policy document at [www.integratpa.com](http://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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	N/A	Coverage is limited to 100 visits per Plan Year. <a href="#">Pre-authorization</a> required. Failure to <a href="#">pre-authorize</a> will result in a penalty.
	<a href="#">Rehabilitation services</a>	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	N/A	Coverage is limited to 100 Days per Plan Year. <a href="#">Pre-authorization</a> required. Failure to <a href="#">pre-authorize</a> will result in a penalty.
	<a href="#">Habilitation services</a>	\$35 <a href="#">copayment</a>	N/A	60 visits Maximum per plan year, includes: Physical, Chiropractic (20 visits per plan year), Occupational, Speech and Cardiac combined
	<a href="#">Skilled nursing care</a>	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	N/A	Coverage is limited to 100 Days per Plan Year. <a href="#">Pre-authorization</a> required. Failure to <a href="#">pre-authorize</a> will result in a penalty.
	<a href="#">Durable medical equipment</a>	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	N/A	<a href="#">Pre-authorization</a> required. Failure to <a href="#">pre-authorize</a> will result in a penalty.
	<a href="#">Hospice services</a>	<a href="#">Deductible</a> , 20% <a href="#">coinsurance</a>	N/A	---none---
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	N/A	You may have to pay for services that are not <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> .
	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

[\* For more information about limitations and exceptions, see the plan or policy document at [www.integratpa.com](http://www.integratpa.com).]

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
• Acupuncture	• Bariatric surgery	• 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 <a href="#">plan</a> document.)	
• 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](http://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](http://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](http://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: 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](http://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, <https://www.myfloridacfo.com/Division/Consumers>. A list of states with Consumer Assistance Programs is available at [www.dol.gov/ebsa/healthreform](http://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 800-959-3518, INTEGRRA Customer Service / Language Line.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-959-3518, INTEGRRA 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, INTEGRRA Customer Service / Language Line.

[Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 800-959-3518, INTEGRRA Customer Service / Language Line.

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



**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 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](#) \$250
- [Specialist copayment](#) \$30
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,570</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$30
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$770</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$30
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$850</b>

\*Note: This plan may have other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row on Page 1.