**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, log on to HCArewards.com or call BConnected at 1-800-566-4114. 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.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

| Important Questions | Answers | Why This Matters |
|---|---|---|
| **What is the overall deductible?** | **In-Network:** $1,000 Individual / $2,000 Family **Out-of-Network:** $1,000 Individual / $2,000 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, emergency services, and certain inpatient and outpatient medical services are covered before you meet your deductible. | 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. $200 Individual / $400 Family for prescription drug coverage. There are no other specific deductibles. | You must pay for all of the costs for these services up to a specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | **In-Network:** $6,550 Individual / $13,100 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?** | Premiums, balance-billed charges, services this plan does not cover, $500 penalty if fail to pre-certify HCA Healthcare facility. **Out-of-network services do not apply.** | 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. Log on to HCArewards.com and click Benefits Providers to link to a list of participating providers | You will pay less if you use a provider in the plan's network and will pay the least if you use an HCA Healthcare network provider. 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 **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 less) | Out-of-Network Provider (You will pay more) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $35 copay per visit | 75% coinsurance | Deductibles apply to coinsurance only. |
| | Specialist visit | 25% coinsurance | 75% coinsurance | Deductibles apply |
| | Preventive care/screening/ immunization | 0% | Not covered | Deductibles do not apply. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check for what your plan will pay. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 25% coinsurance | X-ray: 75% coinsurance<br>Lab: 25% coinsurance | Deductibles apply. Precertification required. |
| | Imaging (CT/PET scans, MRIs) | 25% coinsurance | 75% coinsurance | Deductibles apply. Precertification required. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at **HCArewards.com**<br><br>Insulin (including | Generic drugs | Preferred generic: $0 copay<br><br>Non-preferred generic:<br>• 30-day retail: $10 copay<br>• 90-day retail or mail order: $20 copay | Not covered | Deductibles do not apply. If your facility participates in the maintenance drug program, maintenance drugs must be dispensed in a 90-day supply by a CVS retail pharmacy or Optum home delivery (mail order). Copays on maintenance drugs may vary.. |

For more information about limitations and exceptions, see the plan or policy document at HCArewards.com.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider* (You will pay less) | Out-of-Network Provider (You will pay more) | |
| diabetic supplies) are subject to $25 copay for 30-day supply/$60 copay for 90 day supply | Preferred brand drugs | 30-day retail:<br>40% coinsurance<br>$150 maximum per script<br>90-day retail or mail: $150 copay per prescription | Not covered | Deductibles apply to coinsurance |
| | Non-preferred brand drugs | 30-day retail:<br>60% coinsurance<br>$200 maximum per script<br>90-day retail or mail: $200 copay per prescription | Not covered | Deductibles apply to coinsurance |
| | Specialty drugs | 30-day: $125 copay per prescription | Not covered | Deductibles do not apply |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | **75% coinsurance | Deductibles apply. Precertification required to receive network benefit at out-of-network facility. |
| | Physician/surgeon fees | 25% coinsurance | Physician: 25% coinsurance<br>Surgeon: 75% coinsurance | Deductibles apply |
| **If you need immediate medical attention** | Emergency room care | $200 copay per visit | $200 copay per visit | Deductibles do not apply. $500 penalty if fail to precertify within 48 hours of admittance |
| | Emergency medical transportation | 25% coinsurance | 25% coinsurance | Deductibles do not apply |
| | Urgent care | $40 copay per visit | 25% coinsurance | Deductibles apply to coinsurance |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 25% coinsurance | **75% coinsurance | Deductibles apply. Precertification required. $500 penalty if fail to precertify. |
| | Physician/surgeon fees | 25% coinsurance | Physician: 25% coinsurance<br>Surgeon: 75% coinsurance | Deductibles apply |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider* (You will pay less) | Out-of-Network Provider (You will pay more) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 25% coinsurance | **75% coinsurance | Deductibles apply to out of network only. Precertification required to receive network benefit at out-of-network facility. Progress reviewed after 30 office visits. |
| | Inpatient services | 25% coinsurance | **25% coinsurance | Deductibles apply to out of network only. Precertification required. $500 penalty if fail to precertify. |
| **If you are pregnant** | Office visits | $35 copay | 75% coinsurance | Deductibles apply to coinsurance |
| | Childbirth / delivery professional services | 25% coinsurance | Physician: 25% coinsurance<br>OB/ Surgeon: 75% coinsurance | Deductibles apply |
| | Childbirth / delivery facility services | 25% coinsurance | Prenatal: Not covered<br>Postnatal: 75% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment or coinsurance may apply. Additional cost sharing may apply to maternity care tests and services described elsewhere in the SBC (e.g. ultrasound). Deductibles do not apply if using HCA Healthcare facility. Precertification required. |
| **If you need help recovering or have other special health needs** | Home healthcare | 25% coinsurance | 75% coinsurance | Deductibles apply and a 25% discount at HCA Healthcare facility |
| | Rehabilitation services | 25% coinsurance | 75% coinsurance | Deductibles apply. Precertification required for Out-of-Network provider. Progress reviewed after 30 visits. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider* (You will pay less) | Out-of-Network Provider (You will pay more) | |
| | Habilitation services | 25% coinsurance | 75% coinsurance | Deductibles apply. Precertification required for Out-of-Network provider. Progress reviewed after 30 visits. |
| | Skilled nursing care | 25% coinsurance | 75% coinsurance | Deductibles apply. Precertification required. |
| | Durable medical equipment | 25% coinsurance | 75% coinsurance | Deductibles apply. Precertification required. |
| | Hospice services | 25% coinsurance | 75% coinsurance | Deductibles apply. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

* In the event you can/will travel to an HCA Healthcare facility, enhanced benefits may be available.

**When inpatient or outpatient services are available at a network facility, 75% coinsurance applies for use of an out-of-network facility, regardless of whether you precertify. When inpatient or outpatient services are not available at a network facility, network cost sharing applies.

HCA Healthcare refers to HCA Healthcare, Inc. and it direct or indirect subsidiaries and affiliated partnerships and companies, unless otherwise stated. HCA Healthcare, Inc. is a holding company that has no employees. "Facility" means a facility operated by the subsidiaries and affiliates of HCA Healthcare, Inc.

## 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 (to improve, alter or enhance appearance with some exception)
- Dental care (unless related to an accidental injury to the mouth)
- Hearing aids
- Infertility treatment (once infertility is determined)
- Long-term care
- Routine eye 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
- Non-emergency care when traveling outside the United States (using a network provider)
- Private duty nursing (if medically necessary)
- Routine foot care

**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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, 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:** 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: 1-800-566-4114 or refer to the "Administrative Information" section of the Summary Plan Description found at www.hcarewards.com for additional information. You may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may be able to help you file your appeal. A list of the states with Consumer Assistance Programs and their contact information is available at the Consumer Assistance Programs link on www.dol.gov/ebsa/healthreform. If applicable, you may contact the Consumer Assistance Program in your state for assistance.

**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 1-800-566-4114.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-566-4114.

Chinese (中文): 如果需要中文的帮助， □ □ □ □ □ □ □ 1-800-566-4114.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-566-4114.

*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 | $1,000 |
| Specialist coinsurance | 25% |
| Hospital (facility) coinsurance | 25% |
| Other coinsurance | 25% |

**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 | $1,000 |
| Copayments | $600 |
| Coinsurance | $2,340 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,000** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist coinsurance | 25% |
| Hospital (facility) coinsurance | 25% |
| Other coinsurance | 25% |

**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 | $1,000 |
| Copayments | $280 |
| Coinsurance | $2,130 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$3,470** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist coinsurance | 25% |
| Hospital (facility) coinsurance | 25% |
| Other coinsurance | 25% |

**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 | $460 |
| Copayments | $0 |
| Coinsurance | $480 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$940** |

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