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, call (407) 996-1706. 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 in Self-Service (https://tinyurl.com/InforRosen) or call (407) 996-1706 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$8,550 individual / $17,100 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, health care this plan doesn't cover, balance-billing charges, or any out-of-network charges	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 www.webtpa.com or call 855-479-6453 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, 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay/visit	Not covered	None
	Specialist visit	$20 copay/visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	None 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)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	CT scan - $10 copay/test MRI/PET - $25 copay/test	Not covered	Preauthorization is required for PET scans. Failure to obtain preauthorization can result in a denial of payment.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-800-311-3446.	Generic drugs (Tier 1)	$10 copay/prescription No copay at Walmart or Sam's Club		Covers up to a 90-day supply (retail and mail order prescriptions). Certain medications covered in limited quantities as outlined on page 5 of the Prescription Drug Program Summary of Benefits.
	Preferred brand drugs (Tier 2)	$15 copay/prescription $13 at Walmart or Sam's Club		
	Non-preferred brand drugs (Tier 3)	$30 copay/prescription $25 at Walmart or Sam's Club		
	Specialty drugs	$30 copay		Refer to EHIM plan for a list of non-covered pharmaceuticals.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
	Emergency room care	$75 copay/visit	$75 copay/visit	None

[* For more information about limitations and exceptions, see the plan or policy document Self-Service https://tinyurl.com/InforRosen]

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 immediate medical attention	Emergency medical transportation	No charge	No charge	None
	Urgent care	$35 copay/visit	Not covered	In-network options include Guide Well Emergency Doctors, Night Lite Pediatrics, and CareSpot
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 copay/admission	$1,000 copay/admission	Total inpatient copays per calendar year will not exceed: $1,500 for individual coverage and $3,000 for family coverage.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	Not covered	None
	Inpatient services	$750 copay/admission	Not covered	Total inpatient copays per calendar year will not exceed: $1,500 for individual coverage and $3,000 for family coverage.
If you are pregnant	Office visits	$20 copay/visit	Not covered	None
	Childbirth/delivery professional services	No charge	Not covered	Preauthorization must be obtained for an out of network hospital. Failure to obtain preauthorization can result in a denial of payment.
	Childbirth/delivery facility services	$750 copay/admission	$1,000 copay /admission	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	100 visit limit or 400 hour calendar year max Preauthorization is required.
	Rehabilitation services	No charge	Not covered	60 days maximum per treatment plan
	Habilitation services	No charge	Not covered	60 days maximum per treatment plan
	Skilled nursing care	No charge	Not covered	90 day calendar year maximum. Preauthorization is required.
	Durable medical equipment	No charge	Not covered	Precertification required if over $1,000
	Hospice services	No charge	Not covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered; coverage purchased under separate program.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

[* For more information about limitations and exceptions, see the plan or policy document Self-Service https://tinyurl.com/InforRosen]

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 eye care (Adult) • Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Chiropractic care	• Weight loss programs

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-EBSA (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: WebTPA
Attn: Claims
P.O. Box 99906
Grapevine, TX 76099-9706
855-479-6453

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 855-479-6453.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-479-6453.
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 855-479-6453.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 855-479-6453.

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 Self-Service https://tinyurl.com/InforRosen]

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	$0
Specialist copayment	$20
Hospital copayment	$750
Other copayment	$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	**$11,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$750
Other copayment	$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	**$5,380**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$220
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$280**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$750
Other copayment	$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	**$2,700**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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

WEEKLY INSURANCE RATES 2025

Weekly deductions for health coverage are calculated based on each associate's compensation. A transfer of position may lead to a change in bracket.

WEEKLY HEALTH INSURANCE RATES							
	BRACKET 1	BRACKET 2	BRACKET 3	BRACKET 4	BRACKET 5	BRACKET 6	BRACKET 7
ASSOCIATE							
	$16.66	$20.83	$25.98	$32.71	$40.91	$49.11	$58.93
ASSOCIATE & CHILD							
	$36.01	$45.54	$57.19	$72.69	$91.36	$110.03	$132.44
ASSOCIATE & SPOUSE							
	$37.45	$47.29	$59.35	$75.33	$94.64	$113.94	$137.10
ASSOCIATE & CHILDREN							
	$40.45	$50.85	$63.84	$81.02	$101.76	$122.52	$147.44
ASSOCIATE & FAMILY							
	$54.71	$64.31	$81.02	$103.27	$130.08	$156.88	$189.04

DENTAL ONLY RATES

DENTAL ONLY RATES		
TIER OF COVERAGE	BASIC DHMO	UPGRADE PPO
ASSOCIATE ONLY	$0	$6.96
ASSOCIATE PLUS CHILD(REN)	$2.53	$15.47
ASSOCIATE PLUS SPOUSE	$2.63	$16.99
ASSOCIATE PLUS FAMILY	$5.76	$27.43