



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 1-888-296-7179. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You may view the Glossary at healthcare.gov/sbc-glossary or call 1-888-296-7179 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network---Single Plan: \$1,500 employee Family Plan: \$1,500 person/\$3,000 family Out-of-network---Single Plan: \$3,000 employee Family Plan: \$3,000 person/\$6,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive services</u> and physician office visits are some of the services covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov /coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-network---Single Plan: \$5,000 employee Family Plan: \$5,000 person/\$10,000 family Out-of-network---Single Plan: \$10,000 employee Family Plan: \$10,000 person/\$20,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> is met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See hpiTPA.com or call 1-888-296-7179 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>).
Do you need a referral to see a specialist?	No.	You may see a <u>specialist</u> you choose without a <u>referral</u> .



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	In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copay</u> /visit; <u>deductible</u> waived	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if services are <u>preventive</u> . Then check what <u>plan</u> will pay.
	<u>Specialist</u> visit	\$75 <u>copay</u> /visit; <u>deductible</u> waived	40% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>Screening</u> /Immunizations	No charge; <u>deductible</u> waived	40% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (X-rays, Blood Work) Mammogram & bone density services All other tests	No charge; <u>deductible</u> waived 20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for Imaging
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at hpiTPA.com	Generic drugs--- Retail (30 days)	\$10 <u>copay</u> /prescription	<u>Deductible</u> waived. *maintenance drugs only Certain <u>prescription drugs</u> are subject to Step Therapy. You may be required to use a different <u>prescription drug</u> or pharmaceutical product(s) first.	
	Retail*(90 days)	\$30 <u>copay</u> /prescription		
	Mail Order (90 days)	\$20 <u>copay</u> /prescription		
	Preferred brand drugs— Retail (30 days)	30% <u>coinsurance</u> \$100 max		
	Retail*(90 days)	30% <u>coinsurance</u> \$300 max		
If you have outpatient surgery	Mail Order (90 days)	30% <u>coinsurance</u> \$200 max	40% <u>coinsurance</u>	<u>Preauthorization</u> required
	Non-preferred brand drugs— Retail (30 days)	50% <u>coinsurance</u> \$250 max		
	Retail*(90 days)	50% <u>coinsurance</u> \$750 max		
	Mail Order (90 days)	50% <u>coinsurance</u> \$500 max		
	<u>Specialty</u> drugs— Retail/Mail Order (30 days)	50% <u>coinsurance</u> \$250 max		
If you need immediate medical attention	Facility fee (Ambulatory Surgical Center, etc.) Diagnostic colonoscopies All other services	No charge; <u>deductible</u> waived 20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Copay</u> waived if admitted
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Emergency room care</u> First visit/yr All Subsequent Visits/yr	\$500 <u>copay</u> /visit; <u>deductible</u> waived 20% <u>coinsurance</u>		
If you have a hospital stay	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$100 <u>copay</u> /visit; <u>deductible</u> waived	40% <u>coinsurance</u>	None
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	



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	In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	Limitations, Exceptions, & Other Important Information
Preauthorization required for all hospital admissions & Facility-Based Services provided at a hospital, surgical center, outpatient facility or dialysis center				
If you need mental health, behavioral health, substance abuse services	Outpatient services--- Office Visit	\$35 <u>copay</u> /visit; <u>deductible</u> waived	40% <u>coinsurance</u>	Preauthorization required for Intensive outpatient treatment & Inpatient services
	Intensive outpatient treatment	No charge; <u>deductible</u> waived	40% <u>coinsurance</u>	
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you are pregnant	Office visits--- Prenatal Care	No charge; <u>deductible</u> waived	40% <u>coinsurance</u>	Maternity care may include tests & services described in the SBC (i.e. ultrasound). Requires prenotification prior to delivery and <u>preauthorization</u> for stays over 48 hrs (normal delivery) or 96 hrs (caesarean)
	Postnatal Care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required.
	<u>Rehabilitation services</u> --- Inpatient	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for Inpatient.
	Outpatient	\$75 <u>copay</u> /visit; <u>deductible</u> waived	40% <u>coinsurance</u>	30 visits/yr combined for Occupational, Physical therapies & Chiropractic services.
	<u>Habilitation services</u> --- Early Intervention	20% <u>coinsurance</u>	40% <u>coinsurance</u>	To age 3
	Developmental Delay	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> & visit limits based on services provided
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	60 days/yr. <u>Preauthorization</u> required
	Durable medical equipment--- All other DME Diabetic Supplies	20% <u>coinsurance</u> 20% <u>coinsurance</u> ; <u>deductible</u> waived	40% <u>coinsurance</u> 40% <u>coinsurance</u>	<u>Preauthorization</u> required for seat lifts, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators, including TENS
If your child needs dental or eye care	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required
	Children's eye exam	No charge; <u>deductible</u> waived	40% <u>coinsurance</u>	1 exam/yr
	Children's glasses	Not covered		n/a
	Children's dental check-up	Not covered		n/a

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.)

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|--|---------------------------------------|---------------------|
| • Cosmetic surgery | • Dental care (routine child & adult) | • Long term care |
| • Non-emergency care when traveling outside 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.)

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|----------------------------------|--|---|
| • Acupuncture | • Bariatric Surgery | • Chiropractic care (30 visits/yr with Physical & Occupational therapies) |
| • Hearing aids (1 aid/ear/3 yrs) | • Infertility treatment (\$25,000/lifetime for medical & \$10,000/lifetime for Rx) | • Routine eye care (adult-1 exam/yr) |

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. 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, you can contact the plan at 1-888-296-7179. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 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 1-888-296-7179

Portuguese (Português): De assistência em Português, ligue 1-888-296-7179

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-296-7179

—————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 <u>deductible</u>	\$1,500
■ Specialist <u>copayment</u>	\$75
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>no charge</u>	

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$10
Coinsurance	\$1,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,970

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$1,500
■ Specialist <u>copayment</u>	\$75
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,520

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$1,500
■ Specialist <u>copayment</u>	\$75
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>copayment</u>	\$75

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,200
Copayments	\$900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,100