



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 <u>deductible</u>?	Single Plan: \$500 employee Family Plan: \$500 person/\$1,000 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 <u>deductible</u>?	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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Single Plan: \$2,500 employee Family Plan: \$2,500 person/\$5,000 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 <u>out-of-pocket limit</u>?	<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 <u>network provider</u>?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a <u>referral</u> to see a <u>specialist</u>?	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	Physician and Facility-Based Services		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	\$25 <u>copay</u> /visit; <u>deductible</u> waived		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	\$50 <u>copay</u> /visit; <u>deductible</u> waived		
	<u>Preventive care</u> / <u>Screening</u> /Immunizations	No charge; <u>deductible</u> waived		
If you have a test	<u>Diagnostic test</u> (X-rays, Blood Work) Mammogram & bone density services	No charge; <u>deductible</u> waived	20% <u>coinsurance</u>	<u>Preauthorization</u> required for Imaging
	All other tests	20% <u>coinsurance</u>		
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
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) Retail*(90 days) Mail Order (90 days)	\$10 <u>copay</u> /prescription \$30 <u>copay</u> /prescription \$20 <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.
	Preferred brand drugs— Retail (30 days) Retail*(90 days) Mail Order (90 days)	30% <u>coinsurance</u> \$100 max 30% <u>coinsurance</u> \$300 max 30% <u>coinsurance</u> \$200 max		
	Non-preferred brand drugs— Retail (30 days) Retail*(90 days) Mail Order (90 days)	50% <u>coinsurance</u> \$250 max 50% <u>coinsurance</u> \$750 max 50% <u>coinsurance</u> \$500 max		
	<u>Specialty drugs</u> — Retail/Mail Order (30 days)	50% <u>coinsurance</u> \$250 max		
If you have outpatient surgery	Facility fee (Ambulatory Surgical Center, etc.) Diagnostic colonoscopies	No charge; <u>deductible</u> waived		<u>Preauthorization</u> required
	All other services	20% <u>coinsurance</u>		
	Physician/surgeon fees	20% <u>coinsurance</u>		
If you need immediate medical attention	<u>Emergency room care</u> First visit/yr All Subsequent Visits/yr	\$250 <u>copay</u> /visit; <u>deductible</u> waived 20% <u>coinsurance</u>		<u>Copay</u> waived if admitted
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>		None
	<u>Urgent care</u>	\$50 <u>copay</u> /visit; <u>deductible</u> waived		None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>		<u>Preauthorization</u> required
	Physician/surgeon fees			
Preauthorization required for all hospital admissions & Facility-Based Services provided at a hospital, surgical center, outpatient facility or dialysis center				



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	Physician and Facility-Based Services	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, substance abuse services	Outpatient services--- Office Visit Intensive outpatient treatment	\$25 <u>copay</u> /visit; <u>deductible</u> waived No charge; <u>deductible</u> waived	<u>Preauthorization</u> required for Intensive outpatient treatment & Inpatient services
	Inpatient services	20% <u>coinsurance</u>	
If you are pregnant	Office visits--- Prenatal Care Postnatal Care	No charge; <u>deductible</u> waived 20% <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)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required.
	<u>Rehabilitation services</u> --- Inpatient Outpatient	20% <u>coinsurance</u> \$50 <u>copay</u> /visit; <u>deductible</u> waived	<u>Preauthorization</u> required for Inpatient. 30 visits/yr combined for Occupational, Physical therapies & Chiropractic services. <u>Preauthorization</u> required after 13 visits each for Occupational, Physical & Speech therapies
	<u>Habilitation services</u> --- Early Intervention Developmental Delay	20% <u>coinsurance</u> 20% <u>coinsurance</u>	To age 3 <u>Preauthorization</u> & visit limits based on services provided
	<u>Skilled nursing care</u>	20% <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	<u>Preauthorization</u> required for equipment over \$2,500
	<u>Hospice services</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required
If your child needs dental or eye care	Children's eye exam	No charge; <u>deductible</u> waived	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>	\$500
■ Specialist <u>copayment</u>	\$50
■ 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	\$500
Copayments	\$10
Coinsurance	\$1,600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,170

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>	\$500
■ Specialist <u>copayment</u>	\$50
■ 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	\$500
Copayments	\$600
Coinsurance	\$60
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,180

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$500
■ Specialist <u>copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>copayment</u>	\$50

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	\$500
Copayments	\$600
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,200