



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 1-888-811-3419. 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 1-888-811-3419 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network---Single Plan: \$3,500 employee Family Plan: \$3,500 person/\$7,000 family Out-of-network---Single Plan: \$10,000 employee Family Plan: \$10,000 person/\$20,000 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. In-network <u>preventive services</u> are 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: \$6,900 employee Family Plan: \$6,900 person/\$13,800 family Out-of-network---Single Plan: Unlimited Family Plan: Unlimited	In-network: 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 overall family <u>out-of-pocket limit</u> is met. Out-of-network: This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
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 1-888-811-3419 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You pay less if you use a <u>provider</u> in the <u>plan's network</u> . You 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>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
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	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	50% <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 your <u>plan</u> will pay.
	Specialist visit			
	Preventive care/screening/immunization	No charge; <u>deductible</u> waived		
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at hpiTPA.com	Generic drugs— Retail (30 days) Retail*(90 days)/Mail Order (90 days)	20% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies *maintenance drugs only Certain <u>prescription drugs</u> are subject to Step Therapy. You may be required to use different <u>prescription drug</u> or pharmaceutical product(s) first.
	Preferred drugs— Retail (30 days) Retail*(90 days)/Mail Order (90 days)			
	Non-preferred drugs— Retail (30 days) Retail*(90 days)/Mail Order (90 days)			
	Specialty drugs—30 days Retail or Mail Order			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required
	Physician/surgeon fees			
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent car</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required
	Physician/surgeon fees			
If you need mental health, behavioral health or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for Inpatient services
	Inpatient services			
If you are pregnant	Office visits: Prenatal Care Postnatal Care	No charge; <u>deductible</u> waived 20% <u>coinsurance</u>	50% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <u>Preauthorization</u> required 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>		

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
		In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. 100 visits/yr
	Rehabilitation services— (Occupational, Physical & Speech therapies)	Inpatient 20% <u>coinsurance</u> Outpatient 20% <u>coinsurance</u>	50% <u>coinsurance</u> 50% <u>coinsurance</u>	<u>Preauthorization</u> required for Inpatient & after 5 visits each for Occupational & Physical therapies.
	Habilitation services— (Early Intervention Developmental Delay)	20% <u>coinsurance</u> Not covered	50% <u>coinsurance</u> Not covered	To age 3 n/a
	Skilled nursing care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	120 days/yr. <u>Preauthorization</u> required
	Durable medical equipment	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Please refer to <u>plan</u> document for items requiring <u>preauthorization</u>
	Hospice services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for Inpatient
If your child needs dental or eye care	Children's eye exam	<u>deductible</u> only	50% <u>coinsurance</u>	1 exam/yr
	Children's glasses	Not covered	Not covered	n/a
	Children's dental check-up	Not covered	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.)

- Acupuncture
- Dental care (routine child & adult)
- Non-emergency care when traveling outside U.S.
- Weight loss programs
- Bariatric Surgery
- Habilitation Services—Developmental Delay
- Private Duty Nursing
- Cosmetic surgery
- Long term care
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Routine eye care (adult-1 exam/yr)
- Hearing aids (1 aid/ear/3 yrs to age 18)
- Infertility treatment

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 the plan at 1-888-811-3419. You may also contact the U.S. Department of Labor’s 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 1-888-811-3419; Portuguese (Português): De assistência em Português, ligue 1-888-811-3419

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-811-3419

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 \$3,500
- Specialist coinsurance 20%
- 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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,860

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

- The plan's overall deductible \$3,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other no charge

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:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,720

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

- The plan's overall deductible \$3,500
- Specialist coinsurance 20%
- 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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,400
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,400