



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 <u>deductible</u>?	In-network---Single Plan: \$3,500 employee Family Plan: \$7,000 family Out-of-network---Single Plan: \$10,000 employee Family Plan: \$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> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. In-network <u>preventive services</u> 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>?	In-network---Single Plan: \$7,000 employee Family Plan: \$10,600 person/\$14,000 family Out-of-network---Single Plan: \$20,000 employee Family Plan: \$40,000 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>Preauthorization</u> penalties, <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>?	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 <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	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>	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services are <u>preventive</u> . Then check what your <u>plan</u> will pay.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Preventive care/Screening/Immunization</u>	No charge; <u>deductible waived</u>	40% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-rays, blood work):	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for Imaging
	<u>Imaging</u> (CT/PET scan, MRI)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
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:		Not covered	<u>Deductible</u> applies except to <u>preventive care</u> drugs which are covered at no cost sharing.
	Retail Select Program (34 days)	\$5 <u>copay</u> /prescription		
	Retail Non-Select Program (34 days)	\$25 <u>copay</u> /prescription		
	Compound Drug (34 days)	\$25 <u>copay</u> /prescription		
	Retail (90 days)	\$15 <u>copay</u> /prescription		
	Mail Order (90 days)	\$20 <u>copay</u> /prescription		
Preferred drugs:		Not covered		
Retail Select Program (34 days)	\$25 <u>copay</u> /prescription			
Retail Non-Select Program (34 days)	\$45 <u>copay</u> /prescription			
Retail (90 days)	\$75 <u>copay</u> /prescription			
Mail Order (90 days)	\$80 <u>copay</u> /prescription			
Non-preferred drugs:		Not covered		
Retail Select Program (34 days)	\$50 <u>copay</u> /prescription			
Retail Non-Select Program (34 days)	\$70 <u>copay</u> /prescription			
Retail (90 days)	\$150 <u>copay</u> /prescription			
Mail Order (90 days)	\$155 <u>copay</u> /prescription			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery ctr)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required or you pay 50% more
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
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 care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None



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 have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required or you pay 50% more
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for Inpatient or you pay 50% more
	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 and services described elsewhere in SBC. <u>Preauthorization</u> required for stays over 48 hrs (normal delivery) or 96 hrs (caesarean) or you pay 50% more
	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>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for Inpatient or you pay 50% more. <u>Preauthorization</u> required for Outpatient Physical & Speech therapies after 13 visits each.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Early Intervention to age 3 <u>Preauthorization</u> requirements and visit limits are based on services provided for Learning Deficiencies & Behavioral problems
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required or you pay 50% more
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for insulin pumps/supplies, equipment over \$2,500, Out-of-network providers
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	n/a
	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.)

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

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

- Acupuncture
- Infertility treatment
- Chiropractic care
- Hearing aids (1 aid/ear/36 months \$2,500 max Age 22 & up, no max under Age 22)

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**

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$10
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,870

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**

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,500
Copayments	\$60
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,600

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**

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	\$400
The total Mia would pay is	\$2,800