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 1-877-734-6692. 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 1-877-734-6692 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Single Plan: $1,250 employee Family Plan: $1,250 person/$2,250 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive services and physician office visits are some of the services 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 healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	Yes, for non-preventive care prescription drugs: Single Plan: $100 employee Family Plan: $100 person/$300 per family There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Single Plan: $3,000 employee Family Plan: $3,000 person/$6,000 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 overall family out-of-pocket limit is met.
What is not included in the out-of-pocket limit?	Premiums, Preauthorization penalties, balance billing charges, prescription drug deductible, prescription drug copayments, and health care this plan doesn't cover.	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 hpiTPA.com or call 1-877-734-6692 for a list of network providers.	This plan uses a provider network. You pay less if you use a provider in the plan's network. You 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?	No.	You may see a specialist you choose without a referral.

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: In-Network Provider (You pay the least)	What You Will Pay: 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	$25 copay/visit; deductible waived	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services are preventive. Then check what your plan will pay.
	Specialist visit	$45 copay/visit; deductible waived	Not covered	
	Preventive care/Screening/Immunization	No charge; deductible waived	Not covered	
If you have a test	Diagnostic test (X-rays, Blood work)	No charge; deductible waived	Not covered	Preauthorization required for Imaging
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	
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-day supply)	$15 copay/prescription; deductible waived	Not covered	*Maintenance drugs only Prescription drug specific deductible of $100 (Single Plan) and $100 per person up to $300 per family (Family Plan) applies except to preventive care drugs. Certain prescription drugs are subject to Step Therapy. You may be required to use a different prescription drug or pharmaceutical product(s) first. Prescription drug specific out-of-pocket limit of $4,000 (Single Plan) and $4,000 per person up to $8,000 per family (Family Plan)
	Retail* (90-day supply)	$45 copay/prescription; deductible waived		
	Mail Order (90-day supply)	$30 copay/prescription; deductible waived		
	Preferred brand drugs— Retail (30-day supply)	$25 copay/prescription		
	Retail* (90-day supply)	$75 copay/prescription		
	Mail Order (90-day supply)	$50 copay/prescription		
	Non-preferred brand drugs— Retail (30-day supply)	$40 copay/prescription		
	Retail* (90-day supply)	$120 copay/prescription		
	Mail Order (90-day supply)	$80 copay/prescription		
	Specialty drugs--- Retail Only (30-day supply)	$400 copay/prescription; deductible waived		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Preauthorization required for spinal & potentially cosmetic procedures
	Physician/surgeon fees	20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	$175 copay/visit then 20% coinsurance; deductible waived		Copayment waived if admitted
	Emergency medical transportation	20% coinsurance after In-network deductible		None
	Urgent care	$100 copay/visit; deductible waived	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Preauthorization required
	Physician/surgeon fees	20% coinsurance	Not covered	

Failure to obtain precertification for inpatient admissions and outpatient surgical procedures may result in a reduction in benefits.

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 mental health, behavioral health, substance abuse services	Outpatient services--- Office Visits	$25 copay/visit; deductible waived	Not covered	Preauthorization required for Inpatient services
	Intensive outpatient treatment	No charge; deductible waived		
	Inpatient services	20% coinsurance	Not covered	
If you are pregnant	Office visits--- Prenatal Care	No charge; deductible waived	Not covered	Maternity care may include tests and services described elsewhere in SBC. Preauthorization required for stays over 48 hrs (normal delivery) or 96 hrs (caesarean)
	Postnatal Care	20% coinsurance		
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Preauthorization required. 60 visits/yr
	Rehabilitation services— Inpatient	20% coinsurance	Not covered	60 days/yr with Skilled nursing care. Preauthorization required for Inpatient. 30 visits/yr combined for Physical, Occupational & Speech therapies. Preauthorization required after 5 visits each for Occupational & Physical therapies.
	Outpatient	$45 copay/visit; deductible waived	Not covered	
	Habilitation services— Early Intervention	20% coinsurance	Not covered	To age 3 Preauthorization and visit limits are based on services provided.
	Developmental Delay	20% coinsurance	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	60 days/yr with Inpatient rehab. Preauthorization required
	Durable medical equipment	20% coinsurance	Not covered	Please refer to plan document for items requiring preauthorization
	Hospice services	20% coinsurance	Not covered	Preauthorization required for Inpatient
If your child needs dental or eye care	Children's eye exam	No charge; deductible waived	Not covered	1 exam/yr
	Children's glasses	Not covered	Not covered	n/a
	Children's dental check-up	Not covered	Not covered	n/a

Failure to obtain precertification for inpatient admissions and outpatient surgical procedures may result in a reduction in benefits.

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.)		
• Cosmetic surgery	• Dental care (routine child & adult)	• Infertility treatment
• Long term care	• Non-emergency care when traveling outside U.S.	• 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.)		
• Acupuncture (10 visits/yr or $1,000/yr)	• Bariatric Surgery	• Chiropractic care (30 visits/yr)
• Hearing aids ($5,000/yr)	• Private Duty Nursing (Outpatient only $2,000/yr)	• Routine eye care (adult)

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 1-877-734-6692. 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 1-877-734-6692;
Portuguese (Português): De assistència em Português, ligue 1-877-734-6692
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-734-6692

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	**$1,250**
Specialist copayment	**$45**
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:

Cost Sharing	
Deductibles	$1,250
Copayments	$10
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,720**

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

The plan's overall deductible	**$1,250**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	**$1,250**
Specialist copayment	**$45**
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	**$2,400**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$400
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,710**