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 1-888-682-4269. 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 1-888-682-4269 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Single Plan: $4,000 employee Family Plan: $4,000 person/$8,000 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 are 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Single Plan: $6,000 employee Family Plan: $6,000 person/$12,000 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 the overall family out-of-pocket limit is met.
What is not included in the out-of-pocket limit?	Preauthorization penalties, premiums, balance-billing charges 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 www.employershealthnetwork.com or call 1-888-682-4269 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			Limitations, Exceptions, & Other Important Information
		Participating Physician Providers & Facilities	Non-Participating Facilities	Non-Participating Physician Providers	
		(You pay the least)		(You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	Not applicable	10% coinsurance	You may have to pay for services that aren't preventive. Ask provider if services are preventive. Then check what plan will pay. Preauthorization may be required.
	Specialist visit				
	Preventive care/Screening/Immunization	No charge; deductible waived			
If you have a test	Diagnostic test (X-rays, Blood work)	10% coinsurance			Preauthorization required for Imaging
	Imaging (CT/PET scans, MRIs)				
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at truerx.com	Generic drugs— Retail (31 days) Retail*(90 days)/Mail Order (90 days)	 $10 copay/prescription $25 copay/prescription			Deductible applies except to preventive care drugs. *maintenance drugs only Certain prescription drugs are subject to Step Therapy. You may be required to use different prescription drug/pharmaceutical product(s) first.
	Preferred drugs— Retail (31 days) Retail*(90 days)/Mail Order (90 days)	 $35 copay/prescription $87.50 copay/prescription		Not covered	
	Non-preferred drugs— Retail (31 days) Retail*(90 days)/Mail Order (90 days)	 $60 copay/prescription $150 copay/prescription			
	Specialty drugs--	Not Covered			
	Coverage listed for medications greater than $350 for a 30-day supply under the pharmacy benefit is only applicable if the SHARx program fails to provide a solution. The plan may also allow for a 60-day grace period for urgent medications to allow time to complete the advocacy process.				
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery ctr)	10% coinsurance			Preauthorization required
	Physician/surgeon fees	10% coinsurance	Not applicable	10% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance after In-network deductible			None
	Emergency medical transportation	10% coinsurance			None
	Urgent care	10% coinsurance			None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance		Not applicable	Preauthorization required or you pay 10% more
	Physician/surgeon fees	10% coinsurance	Not applicable	10% coinsurance	
Note: 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	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Participating Physician Providers & Facilities	Non-Participating Facilities	Non-Participating Physician Providers	
		(You pay the least)		(You pay the most)	
If you need mental health, behavioral health, substance abuse services	Outpatient services	10% coinsurance			Preauthorization required for Intensive Outpatient Treatment
	Inpatient services	10% coinsurance		Not applicable	Preauthorization required or you pay 10% more
If you are pregnant	Office visits--- Prenatal Care Postnatal Care	No charge; deductible waived 10% coinsurance	Not applicable	No charge; deductible waived 10% coinsurance	Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Requires pre-notification prior to delivery and preauthorization for stays over 48 hrs (normal delivery) or 96 hrs (caesarean) or you pay 10% more
	Childbirth/delivery professional services	10% coinsurance		10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance		Not applicable	
If you need help recovering or have other special health needs	Home health care	10% coinsurance			Preauthorization required. 60 visits/yr.
	Rehabilitation services— Inpatient Outpatient	10% coinsurance 10% coinsurance	10% coinsurance 10% coinsurance	Not applicable 10% coinsurance	60 days/yr with Skilled nursing care. Preauthorization required for Inpatient or you pay 10% more. 20 visits/yr each for Occupational, Physical and Speech Therapies (requires preauthorization after 13 visits each)
	Habilitation services-- Early Intervention Developmental Delay	10% coinsurance 10% coinsurance			To age 3 Preauthorization & visit limits based on services provided
	Skilled nursing care	10% coinsurance		Not applicable	60 days/yr with Inpatient rehab. Preauthorization required or you pay 10% more
	Durable medical equipment	10% coinsurance			Preauthorization required for insulin pumps/supplies, equipment over $2,500, out-of-network providers
	Hospice services— Inpatient Outpatient	10% coinsurance 10% coinsurance		Not applicable 10% coinsurance	Preauthorization required
Note: Preauthorization required for all hospital admissions & facility-based services provided at a hospital, surgical center, outpatient facility or dialysis center.					
If your child needs	Children's eye exam	Not covered			n/a

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
		Participating Physician Providers & Facilities	Non-Participating Facilities	Non-Participating Physician Providers	
		(You pay the least)		(You pay the most)	
dental or eye care	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.)

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

- Chiropractic care (20 visits/yr)
- Hearing aids ($2,500/aid/ear/3 yrs)

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 1-888-682-4269. 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 1-888-682-4269
Portuguese (Português): De assistència em Português, ligue 1-888-682-4269
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-682-4269

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*** **$4,000**
- **Specialist *coinsurance*** **10%**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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	$4,000
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,570**

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

- **The plan's overall *deductible*** **$4,000**
- **Specialist *coinsurance*** **10%**
- **Hospital (facility) *coinsurance*** **10%**
- **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:

Cost Sharing	
Deductibles	$4,000
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,070**

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

- **The plan's overall *deductible*** **$4,000**
- **Specialist *coinsurance*** **10%**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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:

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

The **plan** would be responsible for the other costs of these EXAMPLE covered services.