



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>?	Single Plan: \$3,000 employee Family Plan: \$3,400 person/\$6,000 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. In-network <u>preventive services</u> and routine vision exams 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: \$6,550 employee Family Plan: \$6,550 person/\$13,100 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 penalties</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>?	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
		Participating Physician Providers & Facilities	Non-Participating Facilities	Non-Participating Physician Providers	
		(You pay the least)	(You pay more)	(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>	Not applicable	20% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your provider if services are preventive. Then check what plan will pay. May require <u>preauthorization</u>
	<u>Specialist</u> visit	20% <u>coinsurance</u>	Not applicable	20% <u>coinsurance</u>	
	<u>Preventive care/Screening/Immunization</u>	No charge; <u>deductible</u> waived	No charge; <u>deductible</u> waived	No charge; <u>deductible</u> waived	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required for Imaging
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <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: Retail (30 days)	\$15 <u>copay</u> /prescription		Not covered	<u>Deductible</u> applies except to <u>preventive care</u> drugs.. *maintenance drugs 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. <i>SharxRx Specialty Drugs:</i> <u>Specialty</u> drugs that cost at least \$350/month are coordinated through SHARx. Please contact SHARx at 1-314-451-3555 option 1 or sharx@sharxplan.com for more information
	Retail (90 days)*/Mail Order (90 days)	\$30 <u>copay</u> /prescription			
	Preferred brand drugs: Retail (30 days)	\$30 <u>copay</u> /prescription		Not covered	
	Retail (90 days)*/Mail Order (90 days)	\$60 <u>copay</u> /prescription			
Non-preferred brand drugs: Retail (30 days)	\$50 <u>copay</u> /prescription		Not covered		
Retail (90 days)*/Mail Order (90 days)	\$150 <u>copay</u> /prescription				
<u>Specialty</u> drugs: Retail (30 days)	\$100 <u>copay</u> /prescription		Not covered		
Mail Order (90 days)	\$300 <u>copay</u> /prescription				
	Please refer to <u>plan</u> document for coverage requirements & other limitations related to <u>specialty</u> drugs				
If you have outpatient surgery	Facility fee (ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> required or you pay \$300 more.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not applicable	20% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room</u> care		20% <u>coinsurance</u>		None
	<u>Emergency medical transportation</u>		20% <u>coinsurance</u>		None
	<u>Urgent care</u>		20% <u>coinsurance</u>		None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	20% <u>coinsurance</u>	Not applicable	<u>Preauthorization</u> required or you pay \$300 more.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not applicable	20% <u>coinsurance</u>	



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		Participating Physician Providers & Facilities	Non-Participating Facilities	Non-Participating Physician Providers		
		(You pay the least)	(You pay more)	(You pay the most)		
If you need mental health, behavioral health, substance abuse services	Outpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization required for intensive outpatient treatment	
	Inpatient services	Not applicable	20% <u>coinsurance</u>	Not applicable	Preauthorization required or you pay \$300 more.	
If you are pregnant	Office visits	No charge; <u>deductible</u> waived	Not applicable	20% <u>coinsurance</u>	Maternity care may include tests & services described elsewhere in SBC. Requires pre-notification prior to delivery & <u>preauthorization</u> for stays over 48 hrs (normal delivery)/96 hrs (caesarean) or you pay \$300 more.	
	Childbirth/delivery professional services	No charge; <u>deductible</u> waived	Not applicable	20% <u>coinsurance</u>		
	Childbirth/delivery facility services	Not applicable	20% <u>coinsurance</u>	Not applicable		
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Preauthorization required.	
	<u>Rehabilitation services</u> —	Inpatient	Not applicable	20% <u>coinsurance</u>	Not applicable	60 days/yr. Preauthorization required for Inpatient or you pay \$300 more. 60 visits/yr combined for Occupational & Physical therapies (<u>preauthorization</u> required after 13 visits each including Speech therapy)
		Outpatient	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Habilitation services</u> —	Early Intervention Developmental Delay Autism Spectrum Disorders Treatment	20% <u>coinsurance</u> Not covered Covered according to service provided			To age 3 n/a Preauthorization required for Applied Behavioral Analysis (ABA)
	<u>Skilled nursing care</u>		Not applicable	20% <u>coinsurance</u>	Not applicable	100 days/yr. Preauthorization required or you pay \$300 more.
	<u>Durable medical equipment</u>		20% <u>coinsurance</u>			Preauthorization required for insulin pumps/supplies, equipment over \$2,500 & for <u>out-of-network</u> providers.
	<u>Hospice services</u> —	Inpatient	Not applicable	20% <u>coinsurance</u>	Not applicable	Preauthorization required.
Outpatient		20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>		



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		Participating Physician Providers & Facilities	Non-Participating Facilities	Non-Participating Physician Providers	
		(You pay the least)	(You pay more)	(You pay the most)	
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	20% <u>coinsurance</u>			2 exams/yr to age 13

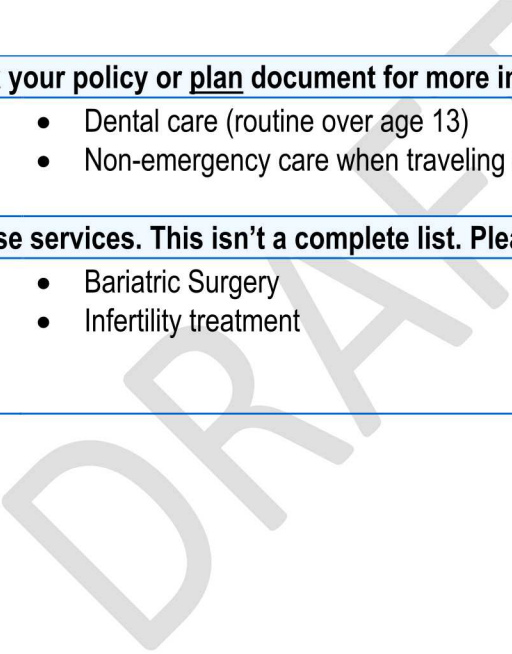
Excluded Services & Other Covered Services:

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
- Long term care
- Routine foot care
- Dental care (routine over age 13)
- Non-emergency care when traveling outside U.S.
- Habilitation Services – Developmental Delay
- Private Duty Nursing

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

- Acupuncture (20 visits/yr)
- Hearing aids (\$2,000/aid/ear/36 months to age 22)
- Weight loss programs (\$150/yr/person;\$300/yr/family combined with Fitness Reimbursement Benefit)
- Bariatric Surgery
- Infertility treatment
- Chiropractic care (20 visits/yr)
- 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 1-888-811-3419. 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 1-888-811-3419

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 <u>deductible</u>	\$3,000
■ Specialist <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$10
Coinsurance	\$1,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,470

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>	\$3,000
■ Specialist <u>coinsurance</u>	20%
■ 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	\$3,000
Copayments	\$200
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3,240

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$3,000
■ Specialist <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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:

Cost Sharing	
Deductibles	\$2,400
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$400
The total Mia would pay is	\$2,800