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?	Single Plan: $250 employee Family Plan: $250 person/$500 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 routine eye exams 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?	No.	You don't have to meet deductibles for specific 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 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 call 1-888-811-3419 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 (You pay the least)	Non-Participating Facilities (You pay more)	Non-Participating Physician Providers (You pay the most)	
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 applicable	$25 copay/visit; deductible waived	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 preauthorization
	Specialist visit	$45 copay/visit; deductible waived	Not applicable	$45 copay/visit; deductible waived	
	Preventive care/Screening/Immunization	No charge; deductible waived	No charge; deductible waived	No charge; deductible waived	
If you have a test	Diagnostic test (x-ray, blood work)	deductible only	deductible only	deductible only	Preauthorization required for Imaging
	Imaging (CT/PET scans, MRIs)	deductible only	deductible only	deductible only	
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 days) Retail (90 days)*/Mail Order (90 days)	$15 copay/prescription $30 copay/prescription		Not covered	Deductible does not apply *maintenance drugs Certain prescription drugs are subject to Step Therapy. You may be required to use different prescription drug or pharmaceutical product(s) first. *SharxRx Specialty Drugs:* Specialty 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
	Preferred brand drugs: Retail (30 days) Retail (90 days)*/Mail Order (90 days)	$30 copay/prescription $60 copay/prescription		Not covered	
	Non-preferred brand drugs: Retail (30 days) Retail (90 days)*/Mail Order (90 days)	$50 copay/prescription $150 copay/prescription		Not covered	
	Specialty drugs: Retail (30 days) Mail Order (90 days) Please refer to plan document for coverage requirements & other limitations related to specialty drugs	$100 copay/prescription $300 copay/prescription		Not covered	
If you have outpatient surgery	Facility fee (ambulatory surgery center)	deductible then; $150 copay/admission	deductible then; $150 copay/admission	deductible then; $150 copay/admission	Preauthorization required or you pay $300 more.
	Physician/surgeon fees	deductible only	Not applicable	deductible only	
If you need immediate medical attention	Emergency room care	deductible then; $250 copay/visit			Copay waived if admitted
	Emergency medical transportation	deductible only			None
	Urgent care	$20 copay/visit; deductible waived			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
		Participating Physician Providers & Facilities (You pay the least)	Non-Participating Facilities (You pay more)	Non-Participating Physician Providers (You pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	deductible then; $250 copay/admission	Not applicable	Preauthorization required or you pay $300 more.
	Physician/surgeon fees	deductible only	Not applicable	deductible only	
If you need mental health, behavioral health, substance abuse services	Outpatient services— Office visit	$25 copay/visit; deductible waived			Preauthorization required for intensive outpatient treatment
	Intensive outpatient treatment	No charge; deductible waived			
	Inpatient services	Not applicable	deductible then; $250 copay/admission	Not applicable	Preauthorization required or you pay $300 more.
If you are pregnant	Office visits	No charge	Not applicable	No charge; deductible waived	Maternity care may include tests & services described elsewhere in SBC. Requires pre-notification prior to delivery & preauthorization for stays over 48 hrs (normal delivery)/96 hrs (caesarean) or you pay $300 more.
	Childbirth/delivery professional services	No charge	Not applicable	No charge; deductible waived	
	Childbirth/delivery facility services	Not applicable	deductible then; $250 copay/admission	Not applicable	
If you need help recovering or have other special health needs	Home health care	deductible only	deductible only	deductible only	Preauthorization required.
	Rehabilitation services— Inpatient	Not applicable	deductible then; $250 copay/admission	Not applicable	60 days/yr. Preauthorization required for Inpatient or you pay $300 more. 60 visits/yr combined for Occupational & Physical therapies (preauthorization required after 13 visits each including Speech therapy)
	Outpatient	$45 copay/visit; deductible waived	$45 copay/visit; deductible waived	$45 copay/visit; deductible waived	
	Habilitation services— Early Intervention	deductible only			To age 3
	Developmental Delay	Not covered			n/a
	Autism Spectrum Disorders Treatment	Covered according to service provided			Preauthorization required for Applied Behavioral Analysis (ABA)
	Skilled nursing care	Not applicable	deductible then; $250 copay/admission	Not applicable	100 days/yr. Preauthorization required or you pay $300 more.

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: Participating Physician Providers & Facilities (You pay the least)	What You Will Pay: Non-Participating Facilities (You pay more)	What You Will Pay: Non-Participating Physician Providers (You pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs (continued)	Durable medical equipment	deductible only	deductible only	deductible only	Preauthorization required for insulin pumps/supplies, equipment over $2,500 & for out-of-network providers.
	Hospice services— Inpatient	Not applicable	deductible only	Not applicable	Preauthorization required.
	Outpatient	deductible only			
If your child needs dental or eye care	Children's eye exam	No charge; deductible waived			1 exam/yr
	Children's glasses	Not covered			n/a
	Children's dental check-up	deductible only			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 assistència 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*** **$250**
- **Specialist *copayment*** **$45**
- **Hospital (facility) *copayment*** **$250**
- **Other *deductible***

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	$250
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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

- **The plan's overall *deductible*** **$250**
- **Specialist *copayment*** **$45**
- **Hospital (facility) *copayment*** **$250**
- **Other *deductible***

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	$100
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$520**

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

- **The plan's overall *deductible*** **$250**
- **Specialist *copayment*** **$45**
- **Hospital (facility) *copayment*** **$250**
- **Other *copayment*** **$45**

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	$250
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$400
The total Mia would pay is	**$900**

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