**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 1-877-906-5730. 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 1-877-906-5730 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network---Single Plan: $3,000 employee<br>Family Plan: $3,000 person/$6,000 family<br>Out-of-Network---Single Plan: $5,000 employee<br>Family Plan: $5,000 person/$15,000 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 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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | In-network---Single Plan: $4,000 employee<br>Family Plan: $4,000 person/$8,000 family<br>Out-of-network---Single Plan: $7,500 employee<br>Family Plan: $7,500 person/$22,500 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 1-877-906-5730 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 | $30 copay/visit; deductible waived | 30% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if services are preventive. Then check what your plan will pay. |
| | Specialist visit | $60 copay/visit; deductible waived | | |
| | Preventive care/screening/immunization | No charge; deductible waived | | |
| **If you have a test** | Diagnostic test (X-rays, Blood Work) | deductible only | 30% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | | | |
| **If you need drugs to treat your illness or condition.** More information about **prescription drug coverage** is available at cap-rx.com or call 1-833-599-1045 | Generic drugs— Retail (30-day supply) | $10 copay/prescription | Not covered | Deductible waived. |
| | Generic drugs— Retail (90-day supply) | $20 copay/prescription | | |
| | Generic drugs— Mail Order (90-day supply) | $20 copay/prescription | | |
| | Preferred drugs— Retail (30-day supply) | $30 copay/prescription | | |
| | Preferred drugs— Retail (90-day supply) | $60 copay/prescription | | |
| | Preferred drugs— Mail Order (90-day supply) | $60 copay/prescription | | |
| | Non-preferred drugs— Retail (30-day supply) | $50 copay/prescription | | |
| | Non-preferred drugs— Retail (90-day supply) | $100 copay/prescription | | |
| | Non-preferred drugs— Mail Order (90-day supply) | $100 copay/prescription | | |
| | Specialty drugs--- Mail Order (30-day supply) | $100 copay/prescription | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | deductible only | 30% coinsurance | Preauthorization required for total joint replacement & non-emergent spine surgeries |
| | Physician/surgeon fees | | | |
| **If you need immediate medical attention** | Emergency room care | $150 copay/visit; deductible waived | | Copay waived if admitted |
| | Emergency medical transportation | deductible only | deductible only | None |
| | Urgent care | $60 copay/visit; deductible waived | | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | deductible only | 30% coinsurance | Preauthorization required or you pay $750 more. |
| | Physician/surgeon fees | | | |

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 or substance abuse services** | Outpatient services— Office visit | No charge; deductible waived | | Preauthorization required for Intensive outpatient treatment. |
| | Intensive outpatient treatment | No charge; deductible waived | | |
| | Inpatient services | deductible only | 30% coinsurance | Preauthorization required or you pay $750 more. |
| **If you are pregnant** | Office visits | No charge; deductible waived | 30% coinsurance; deductible waived | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Requires preauthorization for stays over 48 hrs (normal delivery) or 96 hrs (caesarean) or you pay $750 more. |
| | Childbirth/delivery professional services | | | |
| | Childbirth/delivery facility services | deductible only | 30% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | deductible only | 30% coinsurance | Preauthorization required |
| | Rehabilitation services— Inpatient | deductible only | 30% coinsurance | 60 days/yr with Skilled Nursing Care. Preauthorization required for Inpatient (or you pay $750 more) and Speech therapy. 60 visits/yr combined for Occupational, Physical, Speech, Pulmonary & Cognitive therapies. |
| | Outpatient | $30 copay/visit; deductible waived | 30% coinsurance | |
| | Habilitation services— Early Intervention | Not covered | Not covered | n/a |
| | Developmental Delay | deductible only | 30% coinsurance | Preauthorization & visit limits based on services provided. |
| | Skilled nursing care | deductible only | 30% coinsurance | 60 days/yr with Inpatient rehab. Preauthorization required or you pay $750 more. |
| | Durable medical equipment | deductible only | 30% coinsurance | Preauthorization required for rental over 3 months, equipment over $1,000, neuromuscular stimulator equipment and implantable loop recorders & defibrillators |
| | Hospice services | deductible only | 30% coinsurance | Preauthorization 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.)**

- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (routine child & adult)
- Habilitation Services—Early Intervention
- Infertility Treatment
- Long term care
- Non-emergency care when traveling outside U.S.
- Private Duty Nursing
- Routine eye care (child & adult)
- 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 aids/60 months)

**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 1-877-906-5730. 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 1-877-906-5730
Portuguese (Português): De assistència em Português, ligue 1-877-906-5730
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-906-5730

*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** **$3,000**
- **Specialist copayment** **$60**
- **Hospital (facility) deductible**
- **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 | $3,000 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,070** |

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$60**
- **Hospital (facility) deductible**
- **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 | $900 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,520** |

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

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$60**
- **Hospital (facility) deductible**
- **Other copayment** **$30**

**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 | $1,300 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,800** |