




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 1-888-902-2013. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.hpiTPA.com or call 1-888-902-2013 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>In-network---Single Plan: \$2,800 employee Family Plan: \$3,400 family Out-of-network---Single Plan: \$6,000 employee Family Plan: \$12,000 family</p>	<p>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 policy, the overall family deductible must be met before the plan begins to pay.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care are covered before you meet your deductible.</p>	<p>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 https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>In-network---Single Plan: \$5,000 employee Family Plan: \$10,000 family Out-of-network---Single Plan: \$10,000 employee Family Plan: \$20,000 family</p>	<p>If you have other family members in this plan, the overall family out-of-pocket limit must be met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Preauthorization penalties, premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.hpiTPA.com or call 1-888-902-2013 for a list of network providers.</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will 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.</p>

Do you need a referral to see a specialist ?	No.	You may see a specialist you choose without a referral .
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 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No charge; deductible waived	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.*
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hpiTPA.com .	Generic drugs (Tier 1)	\$15 copay /prescription (30 day retail) \$30 copay /prescription (90 day retail & mail order)	Not covered	Deductible applies except to preventive care drugs which are covered at no cost sharing.
	Preferred brand drugs (Tier 2)	\$40 copay /prescription (30 day retail) \$80 copay /prescription (90 day retail & mail order)	Not covered	Dispense as Written provisions apply. Certain prescription drugs are subject to Step Therapy. You may be required to use different prescription drug or pharmaceutical product(s) first.
	Non-preferred brand drugs (Tier 3)	\$60 copay /prescription (30 day retail) \$120 copay /prescription (90 day retail & mail order)	Not covered	Specialty drugs must be obtained from the specialty pharmacy network . See Covered Services, Prescription Drugs in the Medical Benefits section for coverage requirements and other limitations related to specialty drugs .
	Specialty drugs (Tiers 4 & 5)	\$40 copay /prescription (30 day retail & mail order) \$60 copay /prescription (30 day retail & mail order)	Not covered	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.hpiTPA.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	In-Network deductible ; then 20% coinsurance	None
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Preauthorization is required for Inpatient services. If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits - Prenatal	No charge; deductible waived	40% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required for stays in excess of 48 hours (vaginal); 96 hours (cesarean) If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
	Office visits - Postnatal	20% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.hpiTPA.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	120 visits/year Preauthorization is required.
	Rehabilitation services	Inpatient: 20% coinsurance	40% coinsurance	Preauthorization is required. Rehabilitation hospital 120 visits/year, combined with skilled nursing care. If you don't get preauthorization , benefits could be reduced by \$500
		Outpatient: 20% coinsurance	40% coinsurance	Includes cognitive therapy, occupational therapy, physical therapy, post aural therapy, respiratory therapy, and speech therapy. 20 visits/yr combined for outpatient services Preauthorization is required after the first five visits for Occupational and Physical Therapy.
	Habilitation services	20% coinsurance	40% coinsurance	When covered under the plan, early intervention services are covered until age 3 and plan limits and precertification requirements apply to coverage for developmental delays*
	Skilled nursing care	20% coinsurance	40% coinsurance	120 visits/year, combined with rehabilitation hospital Preauthorization is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization required for seat lifts, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators; see Medical Benefits section for other limitations) If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.hpiTPA.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs (continued)	Hospice services	20% coinsurance	40% coinsurance	Preauthorization for inpatient services is required. If you don't get preauthorization , benefits could be reduced by \$500 of the total cost of the service. 5 bereavement counseling visits per family per lifetime maximum
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 .)		
<ul style="list-style-type: none"> • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care (Adult) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
<ul style="list-style-type: none"> • Acupuncture (20 visits/yr) • Chiropractic care (20 visits/yr) • Hearing aids (\$2,500/person/36months)

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.hpiTPA.com.

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 on how 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: 1-888-902-2013.

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 the 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 1-888-902-2013

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-902-2013

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-902-2013

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-902-2013

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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](#) \$2,800
- [Specialist coinsurance](#) 20%
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$10
Coinsurance	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,270

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$2,800
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles *	\$2,800
Copayments	\$200
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,080

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,800
- [Specialist coinsurance](#) 20%
- 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	\$2,800
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In this example, Mia would pay:

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

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.