**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, please visit **www.hmatpa.com** or call **1-866-206-7920.** 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 **https://www.healthcare.gov/sbc-glossary** or by calling **1-866-206-7920** to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Participating Providers: $2,000 person/$4,000 family, Non-Participating: $10,000 person/$30,000 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. Preventive Care Services, delivered through a participating physician's office, hospital, or other provider 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 https://www.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?** | Participating Providers: $5,000 person /$10,000 family, Non-Participating: $15,000 person/$45,000 family. Medical & Pharmacy maximum out-of-pocket limits combined. | 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 has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums; balance-billing charges; charges in excess of the maximum benefits payable under this plan; penalties for failure to obtain preauthorization; and health care this plan doesn't cover. | Even though you pay these expenses, they do not count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.multiplan.com/phcspracanc or call 1-877-952-7427 for a list of network providers. | 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. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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* For more information about limitations and exceptions, see the plan or policy document at www.hmatpa.com.

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 Provider (You will pay the least) | Non-Participating 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 | $40 Copay/visit | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | None |
| | Specialist visit | $70 Copay/visit | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | None |
| | Other practitioner office visit | $70 Copay/visit | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | Limited to 35 visits combined for all therapies per calendar year. Includes, but is not limited to, Occupational, Physical, and Manipulative therapy. |
| | Preventive care/screening/ immunization | No Copay | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | **Hospital Based:** No Copay, plus amounts that exceed Reasonable and Allowed Amount (Includes Preventive Services received in a hospital/facility setting). Preventive Services are as outlined by the Patient Protection & Affordable Care Act.<br>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 after Annual Deductible | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | **Hospital Based**: 20% after Annual Deductible, plus amounts that exceed reasonable and allowed Amounts (Includes Preventive Services received in a hospital/facility setting).<br>Preventive Services are as outlined by the Patient Protection & Affordable Care Act. *Preauthorization is required. If you don't get pre authorization a $250 penalty will apply per service.* |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | |

* For more information about limitations and exceptions, see the plan or policy document at www.hmatpa.com.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at EHIMRX.com or by calling 800-311-3446 | Generic drugs (Preventive) | No Copay | Not Covered | Preventive prescription services as defined by PPACA. |
| | Generic drugs | $15 Copay | Not Covered | Retail 30-day and 90 day supply. Mail order: 90 day supply |
| | Preferred brand drugs | $50 Copay | Not Covered | |
| | Non-preferred brand drugs | $90 Copay | Not Covered | |
| | Specialty drugs | $300 Copayment | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | | Copay waived if admitted (Inpatient copay would apply). Preauthorization is required. If you don't get pre authorization a $250 penalty will apply per service.* |
| | Physician/surgeon fees | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed Reasonable & Allowed Amount | None |
| **If you need immediate medical attention** | Emergency room care | $500 Copay plus 20% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | | Copay waived if admitted (Inpatient copay would apply). |
| | Emergency medical transportation | 20% Coinsurance after Annual Deductible, plus amounts that exceed the Reasonable and Allowed Amount | | Preauthorization is required for non-emergent transportation. If you don't get pre authorization a $250 penalty will apply per service.* |
| | Urgent care | $75 Copay/visit | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | | Preauthorization is required. If you don't get pre authorization a $250 penalty will apply per service.* |
| | Physician/surgeon fees | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed Reasonable & Allowed | None |

* For more information about limitations and exceptions, see the plan or policy document at www.hmatpa.com.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | | | Amount | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $40 Copay/visit | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | **Psychological Testing**: 20% Coinsurance after Annual Deductible. Preauthorization is required if at hospital. If you don't get pre authorization a $250 penalty will apply per service.* |
| | Inpatient services | 20% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | | **Psychiatrist & Psychologist Services Participating Providers**: 20% Coinsurance, after Annual Deductible. **Psychiatrist & Psychologist Services Non-Participating Providers**: 20% Coinsurance, after Annual Deductible plus amounts that exceed Reasonable and Allowed Amount. Preauthorization is required. If you don't get pre authorization a $250 penalty will apply per service.* |
| **If you are pregnant** | Office visits | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | Cost sharing does not apply for preventive services, Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC. |
| | Childbirth/delivery professional services | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible plus amounts that exceed Reasonable & Allowed Amount | |
| | Childbirth/delivery facility services | 20% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | | |
| **If you need help recovering or have other special health needs** | Home health care | No Copay | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | Limited to 60 visits/year. Preauthorization is required. If you don't get pre authorization a $250 penalty will apply per service.* |
| | Rehabilitation services | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | Preauthorization is required. If you don't get pre authorization a $250 penalty will apply per service.* Limited to 35 visits combined for all therapies per calendar year. Includes, but is not |

* For more information about limitations and exceptions, see the plan or policy document at www.hmatpa.com.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | | | | limited to, Occupational, Physical, and Manipulative therapy. |
| | Habilitation services | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | Preauthorization is required. If you don't get pre authorization a $250 penalty will apply per service.* Limited to 35 visits combined for all therapies per calendar year. Includes, but is not limited to, Occupational, Physical, and Manipulative therapy. |
| | Skilled nursing care | No Copay, plus amounts that exceed Reasonable and Allowed Amount | | Preauthorization is required. If you don't get pre authorization a $250 penalty will apply per service.* |
| | Durable medical equipment | 20% Coinsurance after Annual Deductible | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | Preauthorization is required if greater than $500/item. If you don't get pre authorization a $250 penalty will apply per service.* |
| | Hospice services | No Copay | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | Preauthorization is required. If you don't get pre authorization a $250 penalty will apply per service.* |
| **If your child needs dental or eye care** | Children's eye exam | No Copay | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | Preventive care includes visual screening, as covered under preventive services. (Recommended by Bright Futures Project). |
| | Children's glasses | Not Covered | Not Covered | Excluded Service. |
| | Children's dental check-up | No Copay | 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount | Preventive care includes oral health risk assessment, as covered under preventive services. (Recommended by Bright Futures Project). |

* For more information about limitations and exceptions, see the plan or policy document at www.hmatpa.com.

## 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.)**

- Bariatric surgery,
- Cosmetic Surgery,
- Dental care (Adult),
- Infertility treatment,
- Long-term care,
- Non-emergency care when traveling outside the U.S.,
- Private-duty nursing,
- Routine eye care (Adult)
- Routine foot care, and
- Weight loss programs.

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

- Chiropractic, Limited to 35 visits combined for all therapies per calendar year. Includes, but is not limited to, Occupational, Physical, and Manipulative therapy.
- Hearing aids, (Limited to one (1) device per ear each 36-Month Period), and
- Second Surgical Opinion
- Transplants
- Telemedicine $0 Copay

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

**Does this plan provide Minimum Essential Coverage?** **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 1-866-826-5317.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-826-5317.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-826-5317.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-826-5317.

*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 | $2,000 |
| Specialist *Copayment* | $70 |
| 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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments* | $10 |
| Coinsurance | $2,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,170** |

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

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist *Copayment* | $70 |
| Hospital (facility) *Coinsurance** | 20% |
| Other *Coinsurance* * | 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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $900 |
| Copayments* | $1,200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,120** |

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

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist *Copayment* | $70 |
| 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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,000 |
| Copayments* | $200 |
| Coinsurance | $90 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,290** |

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