
 **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: \$7,000 person/\$15,800 family, Non-Participating: \$10,000 person/\$20,000 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: \$7,900 person / \$15,800 family, Non-Participating: Unlimited person / Unlimited 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 .

 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	\$80 Copay/visit	50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount	None
	Other practitioner office visit	\$80 Copay/visit	50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount	Acupuncture, Chiropractor, Naturopathy, Massage Therapy. Combined benefit year benefit maximum of \$400.00
	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. 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)	No Copay	50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount	Hospital Based: 40% after Annual Deductible, plus amounts that exceed reasonable and allowed Amounts (Includes Preventive Services received in a hospital/facility setting). Preventive Services are as outlined by the Patient Protection & Affordable Care Act. *Preauthorization is required. If you don't get pre authorization benefits could be reduced by 25%.*
	Imaging (CT/PET scans, MRIs)	40% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount	

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	\$10 Copay	Not Covered	Retail limited to 30-day supply or 90-day supply (3 X copay required).
	Preferred brand drugs	\$50 Copay	Not Covered	
	Non-preferred brand drugs	\$100 Copay	Not Covered	Mail Order limited to 90-day (3 X copay required).
	Specialty drugs	\$250 Copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% 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 benefits could be reduced by 25%.*
	Physician/surgeon fees	40% 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/visit plus 40% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount		Copay waived if admitted (Inpatient copay would apply).
	Emergency medical transportation	40% 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 benefits could be reduced by 25%.*
	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)	40% Coinsurance after Annual Deductible plus amounts that exceed Reasonable & Allowed Amount		Preauthorization is required. If you don't get pre authorization benefits could be reduced by 25%.*
	Physician/surgeon fees	40% 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: 40% Coinsurance after Annual Deductible. Preauthorization is required if at hospital. If you don't get pre authorization benefits could be reduced by 25%.*
	Inpatient services	40% Coinsurance after Annual Deductible plus amounts that exceed Reasonable & Allowed Amount		Psychiatrist & Psychologist Services Participating Providers: 40% Coinsurance, after Annual Deductible. Psychiatrist & Psychologist Services Non-Participating Providers: 50% Coinsurance, after Annual Deductible plus amounts that exceed Reasonable and Allowed Amount. Preauthorization is required. If you don't get pre authorization benefits could be reduced by 25%.*
If you are pregnant	Office visits	40% 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	40% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible plus amounts that exceed Reasonable & Allowed Amount	
	Childbirth/delivery facility services	40% 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	40% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable & Allowed Amount	Limited to 120 visits/year. Preauthorization is required. If you don't get pre authorization benefits could be reduced by 25%.*
	Rehabilitation services	40% 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 benefits could be reduced by 25%.*

* 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)	
	Habilitation services	40% 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 benefits could be reduced by 25%.*
	Skilled nursing care	40% Coinsurance after Annual Deductible plus amounts that exceed Reasonable & Allowed Amount		Preauthorization is required. If you don't get pre authorization benefits could be reduced by 25%.*
	Durable medical equipment	40% 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 benefits could be reduced by 25%.*
	Hospice services	40% 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 benefits could be reduced by 25%.*
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).

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](#).)

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

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|--|---|---------------------------|
| • Acupuncture, Chiropractic, Naturopathy, and Massage Therapy services, \$400 combined annual max for alternative care services, | • Hearing aids, \$1,500/device maximum and limited to 1 device per ear every 5 years, and | • Second Surgical Opinion |
| | | • Transplants |

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): Dine'ehgo shika at'ohwol ninisingo, kwijigo 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	\$7,000
■ Specialist Copayment	\$80
■ Hospital (facility) Coinsurance	40%
■ Other Coinsurance	40%

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	\$7,000
Copayments*	\$
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$7,960

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$7,000
■ Specialist Coinsurance	\$80
■ Hospital (facility) Coinsurance	40%
■ Other Coinsurance	40%

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	\$800
Copayments*	\$1,300
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	\$7,000
■ Specialist Copayment	\$80
■ Hospital (facility) Coinsurance	40%
■ Other Coinsurance	40%

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	\$2,100
Copayments*	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,700