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: $3,000 person/ $6,000 family Non-Participating: Not covered	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: $6,850 person/ $13,700 family, Non-Participating: Not Covered Combined out-of-pocket maximum for Medical & Pharmacy.	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 pre-authorization; 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. This plan does not provide coverage if an out of network provider is used and the member will be responsible for the billed charge. 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.

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

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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
		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	$5 Copay/visit	Not Covered	None
	Specialist visit	$10 Copay/visit	Not Covered	None
	Other practitioner office visit	$10 Copay/visit	Not Covered	Acupuncture, Chiropractor, Naturopathy, Massage Therapy. Combined benefit year benefit maximum of $400.
	Preventive care/screening/ immunization	No Copay	Not Covered	**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)	Lab - 50% Coinsurance after Annual Deductible X-Ray - 50% Coinsurance after Annual Deductible	Not Covered	**Hospital Based:** 50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable and Allowed Amount (Includes Preventive Services received in a hospital/facility setting). Pre-authorization is required. If you don't get pre-authorization benefits could be reduced by 25%.*
	Imaging (CT/PET scans, MRIs)	50% Coinsurance after Annual Deductible	Not Covered	

* 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 www.EHIMRX.com or (800) 311-3446	Generic drugs (Preventive)	No Copay	Not Covered	Preventive prescription services as defined by PPACA.
	Generic drugs	$10 Copay	Not Covered	31-60-day supply 2 X copay required 61-90 day supply 2.5 X copay required
	Preferred brand drugs	$55 Copay	Not Covered	
	Non-preferred brand drugs	$85 Copay	Not Covered	
	Specialty drugs	25% Coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance after Annual deductible, plus amounts that exceed Reasonable and Allowed Amount		Pre-authorization is required. If you don't get pre-authorization benefits could be reduced by 25%.*
	Physician/surgeon fees	$10 copay	Not Covered	None
If you need immediate medical attention	Emergency room care	50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable and Allowed Amount		None
	Emergency medical transportation	50% Coinsurance after Annual Deductible, plus amounts that exceed the Reasonable and Allowed Amount		Pre-authorization is required for non-emergent transportation. If you don't get pre-authorization benefits could be reduced by 25%.*
	Urgent care	$10 Copay/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable and Allowed Amount		Pre-authorization is required. If you don't get pre-authorization benefits could be reduced by 25%.*
	Physician/surgeon fees	No Charge	Not Covered	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 Copay/visit Outpatient services-50% Coinsurance after Annual Deductible	Not Covered	**Psychological Testing**: 50% Coinsurance after Annual Deductible. Pre-authorization is required if at hospital. If you don't get pre-authorization benefits could be reduced by 25%.*
	Inpatient services	50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable and Allowed Amount		**Psychiatrist & Psychologist Services Participating Providers**: No Charge. **Psychiatrist & Psychologist Services Non-Participating Providers**: Not Covered. Pre-authorization is required. If you don't get pre-authorization benefits could be reduced by 25%.*
If you are pregnant	Office visits	$5 Copay/visit	Not Covered	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	No Charge	Not Covered	
	Childbirth/delivery facility services	50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable and Allowed Amount		
If you need help recovering or have other special health needs	Home health care	50% Coinsurance after Annual Deductible	Not Covered	Limited to 120 visits/year. Pre-authorization is required. If you don't get pre-authorization benefits could be reduced by 25%.*
	Rehabilitation services	Professional Office Visits: Speech & Hearing Exams - $5 Copay/visit PT/OT/ST/- $5 Copay/visit Outpatient Services-50% Coinsurance after Annual Deductible	Not Covered	Pre-authorization is required. If you don't get pre-authorization benefits could be reduced by 25%.*
	Habilitation services	Professional Office Visits: Speech & Hearing Exams - $5 Copay/visit PT/OT/ST - $5	Not Covered	Pre-authorization 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)	
		Copay/visit Outpatient Services-50% Coinsurance after Annual Deductible		
	Skilled nursing care	50% Coinsurance after Annual Deductible, plus amounts that exceed Reasonable and Allowed Amount		Pre-authorization is required. If you don't get pre-authorization benefits could be reduced by 25%.*
	Durable medical equipment	50% Coinsurance after Annual Deductible	Not Covered	Pre-authorization is required if greater than $500/item. If you don't get pre-authorization benefits could be reduced by 25%.*
	Hospice services	50% Coinsurance after Annual Deductible	Not Covered	Pre-authorization 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	Not Covered	Preventive care includes visual screening assessment, 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	Not Covered	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.)

- 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): 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	$3,000
Specialist *Copayment*	$10
Hospital (facility) *Coinsurance**	50%
Other *Coinsurance**	50%

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	$0
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,860**

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*	$10
Hospital (facility) *Coinsurance**	50%
Other *Coinsurance**	50%

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	$800
Copayments	$700
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,580**

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

The plan's overall deductible	$3,000
Specialist *Copayment*	$10
Hospital (facility) *Coinsurance**	50%
Other *Coinsurance**	50%

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	$1,700
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

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