

 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, visit members.hmatpa.com. 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Network Preventive Services, PPACA required Preventive drugs	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?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. For a list of preferred providers; see www.myproviderlookup.com or call 866-344-3147	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 don't need a referral to see a specialist.	You can see the specialist you choose without a referral.

Questions: Call 1-866-816-6786 or visit us at members.hmatpa.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.



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	Non-Network Provider	
		(You will pay the least)	You will pay the most)	
If you visit a health care provider's office or clinic	<u>Primary care visit to treat an injury or illness</u>	Not Covered	Not Covered	-----none-----
	<u>Specialist visit</u>	Not Covered	Not Covered	-----none-----
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	Benefits are available for evidence based items or services that have in effect a rating "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). http://www.uspreventiveservicestaskforce.org . You may have to pay for services that aren't preventive. Ask your provider if these services needed are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test (x-ray, blood work)</u>	Not Covered	Not Covered	-----none-----
	<u>Imaging (CT/PET scans, MRIs)</u>	Not Covered	Not Covered	-----none-----

Questions: Call 1-866-816-6786 or visit us at members.hmatpa.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Non-Network Provider	
		(You will pay the least)	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.welldynrx.com or call WellDyneRx at 1-888-479-2000	<u>Generic drugs</u>	No Charge	Not Covered	Benefits are limited to Preventive drugs as required by the PPACA.
	<u>Preferred brand drugs</u>	Not Covered	Not Covered	-----none-----
	<u>Non-preferred brand drugs</u>	Not Covered	Not Covered	-----none-----
	<u>Specialty drugs</u>	Not Covered	Not Covered	-----none-----
If you have outpatient surgery	<u>Facility fee (e.g., ambulatory surgery center)</u>	Not Covered	Not Covered	-----none-----
	<u>Physician/surgeon fees</u>			
If you need immediate medical attention	<u>Emergency room care</u>	Not Covered	Not Covered	-----none-----
	<u>Emergency medical transportation</u>	Not Covered	Not Covered	-----none-----
	<u>Urgent care</u>	Not Covered	Not Covered	-----none-----
If you have a hospital stay	<u>Facility fee (e.g., hospital room)</u>	Not Covered	Not Covered	-----none-----
	<u>Physician/surgeon fees</u>			

Questions: Call 1-866-816-6786 or visit us at members.hmatpa.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Non-Network Provider	
		(You will pay the least)	You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	<u>Outpatient services</u>	Not Covered	Not Covered	-----none-----
	<u>Inpatient services</u>	Not Covered	Not Covered	-----none-----
If you are pregnant	<u>Office visits</u>	No Charge Benefits are provided for (and limited to) services as required by PPACA.	Not Covered	Cost sharing does not apply for certain preventive services. See your plan document for specific limitations for covered expenses for routine prenatal care.
	<u>Childbirth/delivery professional services</u>			
	<u>Childbirth/delivery facility services</u>	Not Covered	Not Covered	-----none-----
If you need help recovering or have other special health needs	<u>Home health care</u>	Not Covered	Not Covered	-----none-----
	<u>Rehabilitation services</u>	Not Covered	Not Covered	-----none-----
	<u>Habilitation services</u>	Not Covered	Not Covered	-----none-----
	<u>Skilled nursing care</u>	Not Covered	Not Covered	-----none-----
	<u>Durable medical equipment</u>	Not Covered	Not Covered	-----none-----
	<u>Hospice services</u>	Not Covered	Not Covered	-----none-----
If your child needs dental or eye care	<u>Children's eye exam</u>	No Charge	Not Covered	Coverage is limited as required by PPACA.
	<u>Children's glasses</u>	Not Covered	Not Covered	-----none-----
	<u>Children's dental check-up</u>	No Charge	Not Covered	Coverage is limited to oral health risk assessments as required by PPACA.

Questions: Call 1-866-816-6786 or visit us at members.hmatpa.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.

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 <u>excluded services</u> .)			
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Chiropractic care• Cosmetic surgery	<ul style="list-style-type: none">• Dental care (adult)• Hearing aids• Infertility treatment• Long-term care	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Private-duty nursing• Routine eye care (adult)	<ul style="list-style-type: none">• 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.)			

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 available by calling the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: 1-800-747-9446. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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? No.

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 1-800-747-9446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-747-9446.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-747-9446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-747-9446.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

Questions: Call 1-866-816-6786 or visit us at members.hmatpa.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.

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 <u>deductible</u>	\$0
■ <u>Specialist copay</u>	\$0
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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	\$12,840
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$12,690
The total Peg would pay is	\$12,690

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copay</u>	\$0
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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	\$7,460
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$7,240
The total Joe would pay is	\$7,240

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copay</u>	\$0
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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	\$2,010
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,930
The total Mia would pay is	\$1,930