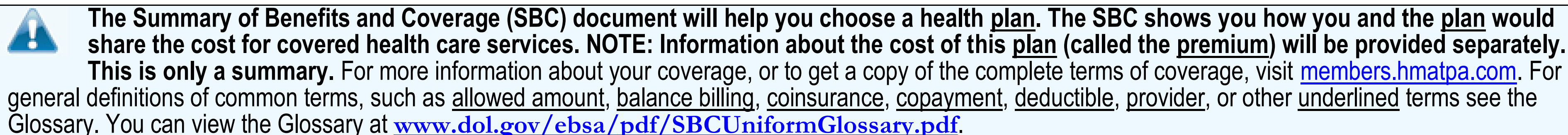
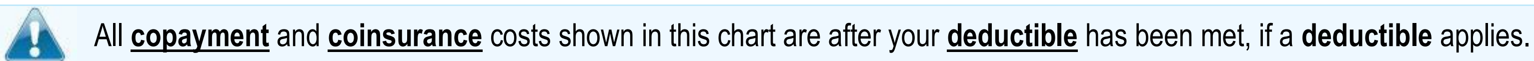


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. 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?	**Network:** **$2,000** Individual/**$4,000** Family	If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of members meets the overall family deductible. You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	**Yes.** Network Preventive Services	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?	**Network:** **$7,900** Individual/**$15,800** Family	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 (unless balanced billing is prohibited), penalties for failure to obtain pre-certification and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
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.



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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	$25 copay per visit, deductible waived	Not Covered	Office Charges limited to exams and basic diagnostic lab and x-ray: Subject to office copay.
	Specialist visit	$50 copay per visit, deductible waived	Not Covered	
	Preventive care/screening/ immunization	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	Diagnostic test (x-ray, blood work)	$50 copay per test, deductible waived	Not Covered	The benefit includes freestanding laboratories and x-ray centers.
	Imaging (CT/PET scans, MRIs)	50% coinsurance after deductible	Not Covered	---------------------none----------------------

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welldynerx.com or call WellDyneRx at 1-888-479-2000	Generic drugs	$20 Copay	Not Covered	Retail: 30-day supply. No Charge for Preventive drugs as required by the PPACA.
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	---------------------none----------------------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	---------------------none----------------------
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	---------------------none----------------------
	Emergency medical transportation	Not Covered	Not Covered	---------------------none----------------------
	Urgent care	$50 copay per visit, deductible waived	Not Covered	---------------------none----------------------
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	---------------------none----------------------
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay per visit, deductible waived	Not Covered	---------------------none----------------------
	Inpatient services	Not Covered	Not Covered	---------------------none----------------------
If you are pregnant	Office visits	Not Covered	Not Covered	Cost sharing does not apply for certain Network Prenatal/Preventive services required by PPACA. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services			
	Childbirth/delivery facility services	Not Covered	Not Covered	---------------------none----------------------
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	---------------------none----------------------
	Rehabilitation services	$50 copay per therapy, deductible waived	Not Covered	Outpatient Physical, Speech and Occupational Therapy: Limited to 20 visits per calendar year combined
	Habilitation services	$50 copay per therapy, deductible waived	Not Covered	
	Skilled nursing care	Not Covered	Not Covered	---------------------none----------------------
	Durable medical equipment	Not Covered	Not Covered	---------------------none----------------------
	Hospice services	Not Covered	Not Covered	---------------------none----------------------
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Coverage is limited as required by PPACA.
	Children's glasses	Not Covered	Not Covered	---------------------none----------------------
	Children's dental check-up	No Charge	Not Covered	Coverage is limited to oral health risk assessments as required by PPACA.

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.)			
• Acupuncture • Bariatric surgery • Chiropractic care • Cosmetic surgery	• Dental care (adult) • Hearing aids • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (adult)	• 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, kwiijigo holne' 1-800-747-9446.

——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 copay** **$50**
- **Hospital (facility) coinsurance** **0%**
- **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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,030
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,410
The total Peg would pay is	**$12,440**

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 copay** **$50**
- **Hospital (facility) coinsurance** **0%**
- **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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,720
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,360
The total Joe would pay is	**$7,080**

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

- **The plan's overall deductible** **2,000**
- **Specialist copay** **$50**
- **Hospital (facility) coinsurance** **0%**
- **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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,390
The total Mia would pay is	**$1,790**

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