



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, call 1-888-340-5487. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You may view the Glossary at [healthcare.gov/sbc-glossary](https://healthcare.gov/sbc-glossary) or call 1-888-340-5487 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                                      | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | In-network---Single Plan: \$1,250 employee<br>Family Plan: \$1,250 person/\$2,500 family<br>Out-of-network---Single Plan: \$2,500 employee<br>Family Plan: \$2,500 person/\$5,000 family     | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                  |
| <b>Are there services covered before you meet your deductible?</b> | Yes. In-network <u>preventive services</u> , physician office visits and routine vision exams are some of the services covered before you meet your <u>deductible</u> .                      | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://healthcare.gov/coverage/preventive-care-benefits">healthcare.gov/coverage/preventive-care-benefits</a> .                                                 |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                                                                          | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>What is the out-of-pocket limit for this plan?</b>              | In-network---Single Plan: \$5,000 employee<br>Family Plan: \$5,000 person/\$10,000 family<br>Out-of-network---Single Plan: \$10,000 employee<br>Family Plan: \$10,000 person/\$20,000 family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> is met.                                                                                                                                                                                                                                                                              |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.                                                                                             | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="https://hpiTPA.com">hpiTPA.com</a> or call 1-888-340-5487 for a list of <u>network providers</u> .                                                                         | This <u>plan</u> uses a <u>provider network</u> . You pay less if you use a <u>provider</u> in the <u>plan's network</u> . You pay the most if you use an <u>out-of-network provider</u> and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | No.                                                                                                                                                                                          | You may see a <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |



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                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                       |                                                  | In-Network Provider (You pay the least)                                       | Out-of-Network Provider (You pay the most) |                                                                                                                                                                                                                                                                                                                          |
| If you visit a health care provider's office or clinic                                                                                                                | Primary care visit to treat an injury or illness | \$25 <u>copay</u> /visit; <u>deductible</u> waived                            | 50% <u>coinsurance</u>                     | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if services are <u>preventive</u> . Then check what your <u>plan</u> will pay.                                                                                                                                                 |
|                                                                                                                                                                       | <u>Specialist</u> visit                          | \$60 <u>copay</u> /visit; <u>deductible</u> waived                            |                                            |                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                       | <u>Preventive care/screening/immunization</u>    | No charge; <u>deductible</u> waived                                           |                                            |                                                                                                                                                                                                                                                                                                                          |
| If you have a test                                                                                                                                                    | <u>Diagnostic test</u> (x-ray, blood work)       | \$50 <u>copay</u> /visit; <u>deductible</u> waived                            | 50% <u>coinsurance</u>                     | None                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                                                        |                                            |                                                                                                                                                                                                                                                                                                                          |
| If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> is available at FairoRx.com or by calling 833-464-9600 | Generic drugs— Retail (30 days)                  | \$10 <u>copay</u> /prescription                                               | Not covered                                | <u>Deductible</u> waived. ACA <u>Preventive care</u> drugs are covered with no cost-sharing.<br><br><u>Specialty</u> Medications and drugs exceeding \$1450 are not covered under the <u>plan</u> , if alternate funding is available. Contact the Navigator Program at 833-464-1020 to obtain your drug if not covered. |
|                                                                                                                                                                       | Retail/WellDyne Mail Order (90 days)             | \$20 <u>copay</u> /prescription                                               |                                            |                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                       | Preferred brand drugs--- Retail (30 days)        | \$30 <u>copay</u> /prescription                                               |                                            |                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                       | Retail/WellDyne Mail Order (90 days)             | \$60 <u>copay</u> /prescription                                               |                                            |                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                       | Non-preferred brand drugs— Retail (30 days)      | \$50 <u>copay</u> /prescription                                               |                                            |                                                                                                                                                                                                                                                                                                                          |
| Retail/WellDyne Mail Order (90 days)                                                                                                                                  | \$100 <u>copay</u> /prescription                 |                                                                               |                                            |                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                       | <u>Specialty</u> drugs (30 days only)            | 20% <u>coinsurance</u> /prescription, if no alternative funding is available. |                                            |                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                       |                                                  |                                                                               |                                            |                                                                                                                                                                                                                                                                                                                          |
| If you have outpatient surgery                                                                                                                                        | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>                                                        | 50% <u>coinsurance</u>                     | <u>Preauthorization</u> required for total joint replacement & non-emergent spine surgeries                                                                                                                                                                                                                              |
|                                                                                                                                                                       | Physician/surgeon fees                           |                                                                               |                                            |                                                                                                                                                                                                                                                                                                                          |
| If you need immediate medical attention                                                                                                                               | <u>Emergency room care</u>                       | \$500 <u>copay</u> /visit; <u>deductible</u> waived                           |                                            | <u>Copay</u> waived if admitted                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                       | <u>Emergency medical transportation</u>          | \$150 <u>copay</u> /trip; <u>deductible</u> waived                            |                                            | None                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                       | Urgent care                                      | \$60 <u>copay</u> /visit; <u>deductible</u> waived                            | 50% <u>coinsurance</u>                     | None                                                                                                                                                                                                                                                                                                                     |
| If you have a hospital stay                                                                                                                                           | Facility fee (e.g., hospital room)               | 20% <u>coinsurance</u>                                                        | 50% <u>coinsurance</u>                     | <u>Preauthorization</u> required.                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                       | Physician/surgeon fees                           |                                                                               |                                            |                                                                                                                                                                                                                                                                                                                          |

Healthcare Excellence Hubs Benefit- Beth Israel Deaconess, Boston Children's Hospital, Brigham and Women's, Dana Farber Cancer Institute, Lahey Clinic, Mass Eye and Ear, New England Baptist Hospital, New England Medical Center, Tufts New England, Cleveland Clinic and University of Michigan Health. Covered Services billed by these facilities are paid at 100% (deductible waived). Physician charges and ancillary expenses related to episodes of care at the facilities listed above will be covered at 100% (deductible waived), when coordinated through CMS nurse advocate line and/or case management prior to receiving treatment.



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                                                                                                                                       |
|------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                   | In-Network Provider (You pay the least)            | Out-of-Network Provider (You pay the most)                                                                                                                          |                                                                                                                                                                                              |
| If you need mental health, behavioral health, substance abuse services | Outpatient services— Office visit                 | \$25 <u>copay</u> /visit; <u>deductible</u> waived | 50% <u>coinsurance</u>                                                                                                                                              | <u>Preauthorization</u> required for Intensive outpatient treatment & Inpatient services                                                                                                     |
|                                                                        | Intensive outpatient treatment                    | 20% <u>coinsurance</u>                             |                                                                                                                                                                     |                                                                                                                                                                                              |
|                                                                        | Inpatient services                                | 20% <u>coinsurance</u>                             |                                                                                                                                                                     |                                                                                                                                                                                              |
| If you are pregnant                                                    | Office visits--- Prenatal Care                    | No charge; <u>deductible</u> waived                | 50% <u>coinsurance</u>                                                                                                                                              | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Requires <u>preauthorization</u> for stays over 48 hrs (normal delivery)/96 hrs (caesarean). |
|                                                                        | Postnatal Care                                    | 20% <u>coinsurance</u>                             |                                                                                                                                                                     |                                                                                                                                                                                              |
|                                                                        | Childbirth/delivery professional services         | 20% <u>coinsurance</u>                             |                                                                                                                                                                     |                                                                                                                                                                                              |
|                                                                        | Childbirth/delivery facility services             |                                                    |                                                                                                                                                                     |                                                                                                                                                                                              |
| If you need help recovering or have other special health needs         | <u>Home health care</u>                           | 20% <u>coinsurance</u>                             | 50% <u>coinsurance</u>                                                                                                                                              | <u>Preauthorization</u> required. 80 visits/yr                                                                                                                                               |
|                                                                        | <u>Rehabilitation services</u> — Inpatient        | 20% <u>coinsurance</u>                             | 50% <u>coinsurance</u>                                                                                                                                              | <u>Preauthorization</u> required for Inpatient & Speech therapy. 60 visits/yr combined for Occupational, Physical & Speech therapies                                                         |
|                                                                        | Outpatient @ Outpatient Facility                  | \$30 <u>copay</u> /visit; <u>deductible</u> waived |                                                                                                                                                                     |                                                                                                                                                                                              |
|                                                                        | Outpatient @ Inpatient Facility                   | 20% <u>coinsurance</u>                             |                                                                                                                                                                     |                                                                                                                                                                                              |
|                                                                        | <u>Habilitation services</u> — Early Intervention | Not covered                                        | Not covered                                                                                                                                                         | n/a                                                                                                                                                                                          |
|                                                                        | Developmental Delay                               | Not covered                                        | Not covered                                                                                                                                                         | n/a                                                                                                                                                                                          |
|                                                                        | <u>Skilled nursing care</u>                       | 20% <u>coinsurance</u>                             | 50% <u>coinsurance</u>                                                                                                                                              | 100 days/yr. <u>Preauthorization</u> required.                                                                                                                                               |
| <u>Durable medical equipment</u>                                       | 20% <u>coinsurance</u>                            | 50% <u>coinsurance</u>                             | <u>Preauthorization</u> required for rental over 3 months, equipment over \$1,000, neuromuscular stimulator equipment and implantable loop recorders/defibrillators |                                                                                                                                                                                              |
| If your child needs dental or eye care                                 | <u>Hospice services</u>                           | 20% <u>coinsurance</u>                             | 50% <u>coinsurance</u>                                                                                                                                              | <u>Preauthorization</u> required                                                                                                                                                             |
|                                                                        | Children’s eye exam                               | No charge; <u>deductible</u> waived                | 50% <u>coinsurance</u>                                                                                                                                              | 1 exam/yr                                                                                                                                                                                    |
|                                                                        | Children’s glasses                                | Not covered                                        | Not covered                                                                                                                                                         | n/a                                                                                                                                                                                          |
|                                                                        | Children’s dental check-up                        | Not covered                                        | Not covered                                                                                                                                                         | n/a                                                                                                                                                                                          |

### 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                         | • Cosmetic surgery                               |
| • Dental care (routine-child & adult) | • Habilitation Services—Developmental delay | • Habilitation Services—Early Intervention       |
| • Infertility treatment               | • Long term care                            | • Non-emergency care when traveling outside U.S. |
| • 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.)

- |                                      |                                            |                        |
|--------------------------------------|--------------------------------------------|------------------------|
| • Chiropractic care (40 visits/yr)   | • Hearing aids (\$2,000/aid/ear/36 months) | • Private Duty Nursing |
| • Routine eye care (adult-1 exam/yr) |                                            |                        |

**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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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 the plan at 1-888-340-5487. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet 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 1-888-340-5487

Portuguese (Português): De assistência em Português, ligue 1-888-340-5487

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-340-5487

—————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 <u>deductible</u>   | \$1,250 |
| ■ Specialist <u>copayment</u>            | \$60    |
| ■ Hospital (facility) <u>coinsurance</u> | 20%     |
| ■ Other <u>copayment</u>                 | \$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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,250        |
| Copayments                        | \$600          |
| Coinsurance                       | \$1,400        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,310</b> |

### 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>   | \$1,250 |
| ■ Specialist <u>copayment</u>            | \$60    |
| ■ Hospital (facility) <u>coinsurance</u> | 20%     |
| ■ Other <u>coinsurance</u>               | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$800          |
| Copayments                        | \$700          |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,520</b> |

### Mia's Simple Fracture

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

|                                          |         |
|------------------------------------------|---------|
| ■ The plan's overall <u>deductible</u>   | \$1,250 |
| ■ Specialist <u>copayment</u>            | \$60    |
| ■ Hospital (facility) <u>coinsurance</u> | 20%     |
| ■ Other <u>copayment</u>                 | \$30    |

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$300          |
| Copayments                        | \$1,100        |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,400</b> |