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, 1-866-631-4966. 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.webtpa.com or call 1-866-631-4966 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500 individual or $4,500 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 is 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?	Yes. $100/individual prescription drug coverage.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	IHP/HCH Logix/Cigna $4,000 individual / $9,000 family; for prescription drug coverage $2,000 individual / $3,000 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?	Balance-billing charges, chiropractic care, surgical treatment of TMJ, preauthorization penalties, 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. See www.hchlogix.com or call 1-800-816-5356 for a list of providers.	You pay the least if you use a provider in Network. You pay more if you use a provider in HCH Logix. 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)

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 (You will pay the least)	HCH Logix Providers and Cigna for out of state dependents	Out-of-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/visit	$25 copay/visit	Not Covered	None.
	Specialist visit	$40 copay/visit	$40 copay/visit	Not Covered	Chiropractic care: 50% coinsurance with a $750 annual maximum.
	Preventive care/screening/ immunization	No charge	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	Not Covered	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	Not Covered	None.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://mp.medimpact.com/ING	Generic drugs (Tier 1)	INTEGRIS retail pharmacies: $10 copay/prescription (30 day supply); $20 copay/prescription (90 day supply)	MedImpact network retail: $20 copay/prescription (30 day supply)		Higher copayments and coinsurances apply when using Non-INTEGRIS Pharmacies (MedImpact Network Pharmacies). Refer to MedImpact for Prescription Drug Benefits.
	Preferred brand drugs (Tier 2)	INTEGRIS retail pharmacies: 20% coinsurance, $25 min/$130 max (30 day supply); 20% coinsurance, $75 min/$250 max (90 day supply)	MedImpact network retail: 30% coinsurance, $35 min/$150 max (30 day supply)		
	Non-preferred brand drugs (Tier 3)	INTEGRIS retail pharmacies: 100% coinsurance, applies to	MedImpact network retail: 100% coinsurance, applies to OOP max		

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	HCH Logix Providers and Cigna for out of state dependents	Out-of-Network Provider (You will pay the most)	
		OOP max			
	Excluded drugs	INTEGRIS retail pharmacies: 100%		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	$1,200 copay/surgery then 40% coinsurance	Not Covered	None.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	Not Covered	None.
If you need immediate medical attention	Emergency room care	10% coinsurance;	40% coinsurance;	40% coinsurance;	Preauthorization is required within 48 hours of hospital admission. 50% penalty for no authorization.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Not Covered	Air ambulance is limited to one/year.
	Urgent care	$25 copay	$25 copay	Not Covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	$1,200 copay/admission then 40% coinsurance	Not Covered	Preauthorization is required. 50% penalty for no authorization.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	Not Covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	Not Covered	None.
	Inpatient services	10% coinsurance	40% coinsurance	Not Covered	Preauthorization may be required. 50% penalty for no authorization.
If you are pregnant	Office visits	$25 copay	20% coinsurance	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	Not Covered	
	Childbirth/delivery facility services	10% coinsurance	$1,200 copay/surgery	Not Covered	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	HCH Logix Providers and Cigna for out of state dependents	Out-of-Network Provider (You will pay the most)	
			then 40% coinsurance		may be required. 50% penalty for no authorization.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Not Covered	Limited to 100 visits annually. Preauthorization is required. 50% penalty for no authorization.
	Rehabilitation services	10% coinsurance	40% coinsurance	Not Covered	None.
	Habilitation services	10% coinsurance	40% coinsurance	Not Covered	None.
	Skilled nursing care	10% coinsurance	40% coinsurance	Not Covered	Preauthorization is required. 50% penalty for no authorization.
	Durable medical equipment	20% coinsurance	20% coinsurance	Not Covered	None.
	Hospice services	10% coinsurance	40% coinsurance	Not Covered	Preauthorization is required. 50% penalty for no authorization.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Not covered	Allowed under PPACA preventive care.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered.

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
- Cosmetic surgery
- Dental care (Adult)
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids (up to age 26)
- Infertility treatment

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options

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

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 1-866-631-4966.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-631-4966.]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-631-4966.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-631-4966.]

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

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

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	$1,500
Specialist copayment (Base)	N/A
Hospital (facility) coinsurance	10%
Other coinsurance	20%

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	**$12,738**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$40
Coinsurance	$1,280
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,880**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copayment (Base)	N/A
Hospital (facility) coinsurance	10%
Other coinsurance	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)*

Total Example Cost	**$7,399**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,500
Copayments	$310
Coinsurance	$1,288
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,153**

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

The plan's overall deductible	$1,500
Specialist copayment (Base)	N/A
Hospital (facility) coinsurance	10%
Other coinsurance	20%

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	**$1,926**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,500
Copayments	$0
Coinsurance	$323
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,823**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: employee.wellness@integrisok.com
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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