
 **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; \$750 individual or \$2,250/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? | For IHP Network \$3,000 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.integrisk.com/ihp for a list of network providers . | You pay the least if you use a provider Network . You pay more if you use a provider in 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 can see the specialist you choose without a referral . |

 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) | 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 | Not covered | None. |
| | Specialist visit | \$40 copay /visit | Not covered | Chiropractic care: 50% coinsurance with a \$750 annual maximum. |
| | Preventive care/screening/immunization | 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 | Not covered | None. |
| | Imaging (CT/PET scans, MRIs) | 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 OOP max | MedImpact network retail: 100% coinsurance , applies to OOP max | |
| | Excluded drugs | INTEGRIS retail pharmacies: 100% | 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) | Out-of-Network Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | Not covered | None. |
| | Physician/surgeon fees | 10% coinsurance | Not covered | None. |
| If you need immediate medical attention | Emergency room care | 10% coinsurance | *10% coinsurance | Preauthorization is required within 48 hours of hospital admission. 50% penalty for no authorization. * Out-of-network deductible and coinsurance applies to IHP Network level. |
| | Emergency medical transportation | 20% coinsurance | *20% coinsurance | Air ambulance is limited to one/year. Non-emergency transport not covered. * Out-of-network deductible and coinsurance applies to IHP Network level. |
| | Urgent care | \$25 copay | *\$25 copay | * Out-of-network deductible and coinsurance applies to IHP Network level. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | Not covered | Preauthorization is required. 50% penalty for no authorization. |
| | Physician/surgeon fees | 10% coinsurance | Not covered | None. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance | Not covered | None. |
| | Inpatient services | 10% coinsurance | Not covered | Preauthorization may be required. 50% penalty for no authorization. |
| If you are pregnant | Office visits | \$25 copay | 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 may be required. 50% penalty for no authorization. |
| | Childbirth/delivery professional services | 10% coinsurance | Not covered | |
| | Childbirth/delivery facility services | 10% coinsurance | Not covered | |
| If you need help recovering or have other special health | Home health care | 10% coinsurance | Not covered | Limited to 100 visits annually. Preauthorization is required. 50% penalty for no authorization. |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| needs | Rehabilitation services | 20% coinsurance | Not covered | None. |
| | Habilitation services | 20% coinsurance | Not covered | None. |
| | Skilled nursing care | 10% coinsurance | Not covered | Preauthorization is required. 50% penalty for no authorization. |
| | Durable medical equipment | 20% coinsurance | Not covered | None. |
| | Hospice services | 10% 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 | Allowed under PPACA preventive care . |
| | Children's glasses | Not covered | Not covered | Not covered. |
| | Children's dental check-up | 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](#).)

| | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing | <ul style="list-style-type: none"> • 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.)

| | | |
|--|---|---|
| <ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care | <ul style="list-style-type: none"> • Hearing aids (up to age 26) | <ul style="list-style-type: none"> • 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 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.

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

[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, kwijigo 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,500 |
| Copayments | \$40 |
| Coinsurance | \$1,280 |
| <i>What isn't covered</i> | |
| 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles* | \$1,500 |
| Copayments | \$310 |
| Coinsurance | \$1,288 |
| <i>What isn't covered</i> | |
| 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles* | \$1,500 |
| Copayments | \$0 |
| Coinsurance | \$323 |
| <i>What isn't covered</i> | |
| 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.