 **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](http://www.webtpa.com) or call 1-866-631-4966 to request a copy.


Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>\$1,500 individual or \$4,500 family;  <a href="#">Out-of-Network</a>; \$4,500/individual or \$13,500/family                      \$750 individual or \$2,250/family;  <a href="#">Out-of-Network</a>; \$2,250/individual or \$6,750/family</p>	<p>Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a> is covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>Yes. \$100/individual <a href="#">prescription drug coverage</a>.</p>	<p>You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>For INTEGRIS \$3,000 individual / \$9,000 family; for HCH Logix/Cigna \$4,000 individual / \$10,700 family; for <a href="#">Out-of-Network</a> unlimited; for <a href="#">prescription drug coverage</a> \$2,000 individual / \$3,000 family.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Balance-billing</a> charges, chiropractic care, surgical treatment of TMJ, <a href="#">preauthorization</a> penalties, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="http://www.hchlogix.com">www.hchlogix.com</a> or call 1-800-816-5356 for a list of <a href="#">providers</a>.</p>	<p>You pay the least if you use a <a href="#">provider</a> in <a href="#">Network</a>. You pay more if you use a <a href="#">provider</a> in HCH Logix. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider</a>'s charge and what your plan pays</p>

		( <a href="#">balance-billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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

(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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

 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	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit	\$25 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit	\$40 <a href="#">copay</a> /visit	40% <a href="#">coinsurance</a>	Chiropractic care: 50% <a href="#">coinsurance</a> with a \$750 annual maximum.
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://mp.medimpact.com/ING">https://mp.medimpact.com/ING</a>	Generic drugs (Tier 1)	INTEGRIS retail pharmacies: \$10 <a href="#">copay</a> /prescription (30 day supply); \$20 <a href="#">copay</a> /prescription (90 day supply)	MedImpact network retail: \$20 <a href="#">copay</a> /prescription (30 day supply)		Higher <a href="#">copayments</a> and <a href="#">coinsurances</a> 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% <a href="#">coinsurance</a> , \$25 min/\$130 max (30 day supply); 20% <a href="#">coinsurance</a> , \$75 min/\$250 max (90 day supply)	MedImpact network retail: 30% <a href="#">coinsurance</a> , \$35 min/\$150 max (30 day supply)		
	Non-preferred brand drugs (Tier 3)	INTEGRIS retail pharmacies: 100% <a href="#">coinsurance</a> , applies to OOP max	MedImpact network retail: 100% <a href="#">coinsurance</a> , applies to OOP max		

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.webtpa.com](http://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	Out-of-Network Provider (You will pay the most)	
	Excluded drugs	INTEGRIS retail pharmacies: 100%	Not covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	\$1,200 <a href="#">copay</a> /surgery then 40% <a href="#">coinsurance</a>	\$2,400 <a href="#">copay</a> /surgery then 60% <a href="#">coinsurance</a>	None.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a> ;	40% <a href="#">coinsurance</a> ;	*40% <a href="#">coinsurance</a> ;	<a href="#">Preauthorization</a> is required within 48 hours of hospital admission. 50% penalty for no authorization. * <a href="#">Out-of-network deductible</a> and <a href="#">coinsurance</a> applies to HCHLogix Network level.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	*20% <a href="#">coinsurance</a>	Air ambulance is limited to one/year. Non-emergency transport not covered. * <a href="#">Out-of-network deductible</a> and <a href="#">coinsurance</a> applies to HCHLogix Network level.
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a>	\$25 <a href="#">copay</a>	*\$25 <a href="#">copay</a>	* <a href="#">Out-of-network deductible</a> and <a href="#">coinsurance</a> applies to HCHLogix Network level.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	\$1,200 <a href="#">copay</a> /admission then 40% <a href="#">coinsurance</a>	\$2,400 <a href="#">copay</a> /admission then 60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. 50% penalty for no authorization.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None.
	Inpatient services	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. 50% penalty for no authorization.
If you are pregnant	Office visits	\$25 <a href="#">copay</a>	\$25 <a href="#">copay</a>	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> ,

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.webtpa.com](http://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	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	\$1,200 <a href="#">copay</a> /surge ry then 40% <a href="#">coinsurance</a>	\$2,400 <a href="#">copay</a> /surge ry then 60% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	Limited to 100 visits annually. <a href="#">Preauthorization</a> is required. 50% penalty for no authorization.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. 50% penalty for no authorization.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> 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 <a href="#">preventive care</a> .
	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](#).)

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

**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"> <li>• Bariatric surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids (up to age 26)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> </ul> |
|---|---|---|

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

- Chiropractic care

**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](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: 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 1-866-631-4966.]

[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.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

<b>Total Example Cost</b>	<b>\$12,738</b>
---------------------------	-----------------

**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
<b>The total Peg would pay is</b>	<b>\$2,880</b>

**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*)

<b>Total Example Cost</b>	<b>\$7,399</b>
---------------------------	----------------

**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
<b>The total Joe would pay is</b>	<b>\$3,153</b>

**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*)

<b>Total Example Cost</b>	<b>\$1,926</b>
---------------------------	----------------

**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
<b>The total Mia would pay is</b>	<b>\$1,823</b>

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](mailto: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.