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, 855-346-5781. 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 1-855-346-5781 request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** Employee/**$1,500 Employee** + Spouse/ **$1,500** Employee + Child(ren)/ **$2,000** Employee + Family **HRA: $500** Employee/**$750** Employee + Spouse/ **$750** Employee + Child(ren)/ **$1,000** Family Deductible includes HRA Amounts	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, First Choice Providers, and Generic Drugs are 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?	No.	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 medical limit for this plan?	In-Network: Employee only **$4,500.** Employee + Spouse, Employee + Child(ren)**$6,750***. Employee + Family **$9,000*.** Out-of-Network: Employee only **Unlimited** Employee + Spouse, Employee + Child(ren) **Unlimited** Employee + Family **Unlimited**	The out-of-pocket limit is the most you could pay in a year for covered medical services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. *Each individual may only meet $6,000.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, imaging penalty, Rx Ancillary charges 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.webtpa.com or call 1-855-346-5781 for a list of network providers.	You pay the least if you use a provider in First Choice network. You pay more if you use a provider in Verity HealthNet or Aetna ASA 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.

* For more information about limitations and exceptions, see the plan or policy document at 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
		First Choice Provider (You will pay the least)	In-Network Provider	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	No Charge	20% Coinsurance	40% Coinsurance	None
	Specialist visit	No Charge	20% Coinsurance	40% Coinsurance	None
	Preventive care/screening/ immunization	No Charge	No Charge	100% of Maximum Allowable Charge (MAC)	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. Plan covered 100% of the MAC. Any billed amount in excess of MAC is not payable by the plan.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% Coinsurance	40% Coinsurance	Imaging requires authorization. Non-authorized services are not covered. *If you receive imaging services in a hospital setting a $150 penalty will apply.
	Imaging (CT/PET scans, MRIs)*	No Charge	20% Coinsurance	40% Coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.medimpact.com**	Generic drugs (Tier 1)	$0 Copayment			Coverage is limited up to a 30- day supply (retail) unless the prescription qualifies and is filled at Retail90 and up to a 90-day supply (home delivery).
	Preferred brand drugs (Tier 2)	20% Coinsurance up to $150 for each 30-day supply			
	Non-preferred brand drugs (Tier 3)	20% Coinsurance up to $150 for each 30-day supply			
	Specialty drugs (Tier 4)	20% Coinsurance up to $150 for each 30-day supply			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)*	No Charge	20% Coinsurance	40% Coinsurance	Authorization required for some services. Non-authorized services are not covered.
	Physician/surgeon fees	No Charge	20% Coinsurance	40% Coinsurance	Authorization required for some services. Non-authorized services are not covered.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		First Choice Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 Copayment	$150 Copayment 20% Coinsurance	$150 Copayment 20% Coinsurance	Copayment will be waived if admitted.
	Emergency medical transportation	No Charge	20% Coinsurance	40% Coinsurance	
	Urgent care	No Charge	20% Coinsurance	40% Coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% Coinsurance	40% Coinsurance	Authorization required for some services. Non-authorized services are not covered.
	Physician/surgeon fees	No Charge	20% Coinsurance	40% Coinsurance	Authorization required for some services. Non-authorized services are not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	20% Coinsurance	40% Coinsurance	Authorization required for some services. Non-authorized services are not covered.
	Inpatient services	No Charge	20% Coinsurance	40% Coinsurance	
If you are pregnant	Office visits	No Charge	20% Coinsurance	40% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior authorization required over 48/96 hours. Non-authorized services are not covered. Maternity care is not covered for dependent children.
	Childbirth/delivery professional services	No Charge	20% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility services	No Charge	20% Coinsurance	40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge	20% Coinsurance	40% Coinsurance	Prior authorization required. Non-authorized services are not covered. Limited to 60 visits per calendar year. Must be prescribed by a physician. Plan of care required.
	Rehabilitation services	No Charge	20% Coinsurance	40% Coinsurance	Prior authorization required for Rehabilitative Services and limited to 90 days per calendar year. Non-authorized services are not covered.
	Habilitation services	Not Covered	Not Covered	Not Covered	
	Skilled nursing care	No Charge	20% Coinsurance	40% Coinsurance	Prior authorization required. Non-

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		First Choice Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
					authorized services are not covered. Limited to 90 days per calendar year.
	Durable medical equipment	No Charge	20% Coinsurance	40% Coinsurance	Prior authorization required over $1,000. Non-authorized services are not covered.
	Hospice services	No Charge	20% Coinsurance	40% Coinsurance	None.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	1 routine exam annually age 16 and over. Any billed amount in excess of MAC is not payable by the plan.
	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.)

- Cosmetic Surgery
- Non-emergency care when traveling outside the U.S.
- Dental Care
- Long-Term Care
- Private-duty nursing
- 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
- Bariatric Surgery
- Hearing Aids
- Acupuncture
- 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: Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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

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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 1-855-346-5781.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-346-5781.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-346-5781.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'1-855-346-5781.

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**	**$1000**
Specialist [cost sharing]	**20%**
■ **Hospital (facility)** [cost sharing]	**20%**
■ **Other** [cost sharing]	**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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1000
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,360**

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

■ **The plan's overall deductible**	**$1000**
■ **Specialist** [cost sharing]	**20%**
■ **Hospital (facility)** [cost sharing]	**20%**
■ **Other** [cost sharing]	**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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

■ **The plan's overall deductible**	**$1000**
■ **Specialist** [cost sharing]	**20%**
■ **Hospital (facility)** [cost sharing]	**20%**
■ **Other** [cost sharing]	**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	**$2,750**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1000
Copayments	$150
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,450**

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