



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, please visit [www.hmatpa.com](http://www.hmatpa.com) or call 1-866-826-5317. 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 <https://www.healthcare.gov/sbc-glossary> or by calling 1-866-826-5317 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	Participating Providers: \$1,350 person/\$2,700 family; Non-Participating Providers: \$5,000 person / \$10,000 family	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> . Plan Deductible is combined for Medical and Pharmacy services.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive Care Services</a> , delivered through a participating physician's office, hospital, or other provider are covered before you meet your <a href="#">deductible</a> .	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> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical Participating Providers: \$3,000 person /\$6,000 family, Non-Participating: \$5,000 person/\$10,000 family. Combined maximum out of pocket for Pharmacy & Medical.	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> ; <a href="#">balance-billing</a> charges; charges in excess of the maximum benefits payable under this <a href="#">plan</a> ; penalties; and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myCigna.com">www.myCigna.com</a> for a list of participating providers through the Cigna network.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . 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 provider's charge and what your <a href="#">plan</a> pays ( <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> .



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
		Participating Provider (You will pay the least)	Non-Participating 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 after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. *Includes Preventive Services only as outlined by the Patient Protection & Affordable Care Act.
	Specialist visit	\$25 copay/visit after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	None.
	Other practitioner office visit	\$35 copay/visit after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Acupuncture, Chiropractor, Naturopath. Combined benefit year benefit maximum of \$400.00
	Preventive care/screening/immunization	No copay	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.*Includes Preventive Care Office Visit. Preventive Services only as outlined by the Patient Protection & Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	0% Coinsurance for Preventive Services only, as outlined by the Patient Protection & Affordable Care Act. Preauthorization is NOT required for Blood Work, except for Genetic Testing. If you don't get pre authorization benefits could be reduced by 25%*
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about prescription drug coverage is available at <a href="http://www.welldyneRx.com">www.welldyneRx.com</a>	Generic drugs	\$25 copay after annual deductible	Not Covered	Retail limited to 31-day supply or 90-day supply (3 X copay required). Mail Order limited to 90-day (2 X copay required). <b>Specialty Preferred Brand:</b> \$40 copay <b>Specialty Non-Preferred Brand:</b> \$55 copay
	Preferred brand drugs	\$40 copay after annual deductible	Not Covered	
	Non-preferred brand drugs	\$55 copay after annual deductible	Not Covered	
	Specialty drugs	\$25 copay after annual deductible (generic)	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$200 copay after annual deductible	\$200 Copayment after annual deductible, plus amounts that exceed the Reasonable & Allowed Amount	Copay waived if admitted (Inpatient copay would apply). Preauthorization is required. If you don't get pre authorization benefits could be reduced by 25%.*
	Physician/surgeon fees	20% coinsurance after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	None
<b>If you need immediate medical attention</b>	Emergency room care	\$200 Copayment after annual deductible	\$200 Copayment after annual deductible, plus amounts that exceed the Reasonable & Allowed Amount	Copay waived if admitted (Inpatient copay would apply).
	Emergency medical transportation	\$250 Copayment after annual deductible	\$250 Copayment after annual deductible, plus amounts that exceed the Reasonable & Allowed Amount	Preauthorization is required for non-emergent transportation. If you don't get pre authorization benefits could be reduced by 25%.*
	Urgent care	\$35 copay/visit after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$150 copay per day, up to three days after annual deductible	\$150 copay per day up to 3 days, after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Preauthorization is required. If you don't get pre authorization benefits could be reduced by 25%.*

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay/visit after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	<b>Psychological Testing:</b> 20% coinsurance after annual deductible. Preauthorization is required if at hospital. If you don't get pre authorization benefits could be reduced by 25%*
	Inpatient services	\$150 copay per day, up to three days after annual deductible	\$150 copay per day up to 3 days, after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	<b>Psychiatrist &amp; Psychologist Services:</b> 20% coinsurance after annual deductible. Preauthorization is required if at hospital. If you don't get pre authorization benefits could be reduced by 25%*
If you are pregnant	Office visits	20% coinsurance after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Cost sharing does not apply for preventive services, Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Copay waived if admitted (Inpatient copay would apply).
	Childbirth/delivery professional services	20% coinsurance after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	
	Childbirth/delivery facility services	\$150 copay per day, up to three days after annual deductible	\$150 copay per day up to 3 days, after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Limited to 120 visits/year. Preauthorization is required. If you don't get pre authorization benefits could be reduced by 25%.*
	Rehabilitation services	\$35 copay/visit after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Preauthorization is required after the first initial 5 visits. If you don't get pre authorization benefits could be reduced by 25%.*

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Habilitation services	\$35 copay/visit after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Preauthorization is required after the first initial 5 visits. If you don't get pre authorization benefits could be reduced by 25%.*
	Skilled nursing care	\$150 copay per day, up to three days after annual deductible	\$150 copay per day up to 3 days, after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Preauthorization is required. If you don't get pre authorization benefits could be reduced by 25%.*
	Durable medical equipment	20% coinsurance after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Preauthorization is required. If you don't get pre authorization benefits could be reduced by 25%.*
	Hospice services	\$35 copay/visit after annual deductible	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Preauthorization is required. If you don't get pre authorization benefits could be reduced by 25%.*
If your child needs dental or eye care	Children's eye exam	No copay	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Preventive care includes a visual screening assessment, as covered under preventive services. (Recommended by Bright Futures Project).
	Children's glasses	Not Covered	Not Covered	Excluded Service. (If vision is elected, see Other Covered Services below)
	Children's dental check-up	No copay	50% Coinsurance after Annual Deductible plus amounts that exceed the Reasonable & Allowed Amount	Preventive care includes an oral health risk assessment, as covered under preventive services. (Recommended by Bright Futures Project).

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

### 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](#).)

- Bariatric surgery,
- Cosmetic Surgery,
- Dental care (Adult),
- Infertility treatment,
- Long-term care,
- Non-emergency care when traveling outside the U.S.,
- Private-duty nursing,
- Routine foot care, and
- Weight loss programs.

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture, Chiropractic, Naturopathy, and Massage Therapy services, \$400 combined annual max for alternative care services,
- Hearing aids, \$1,500/device maximum and limited to 1 device per ear every 5 years
- Routine eye care including Vision Exam, Lenses, Frames, Contact Lens, Fitting, Lasik Surgery In Lieu Of Glasses, \$250 annual maximum benefit
- Second Surgical Opinion
- Transplants

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa). 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### Does this plan meet the 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 1-866-826-5317.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-826-5317.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-826-5317.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-826-5317.

-----*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,350
■ <a href="#">Specialist</a> Copayment	\$25
■ Hospital (facility) Copayment*	\$150
■ 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>\$12,840</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments*	\$450
Coinsurance	\$690
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,550</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,350
■ <a href="#">Specialist</a> Copayment	\$25
■ Hospital (facility) Copayment*	\$150
■ 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>\$7,460</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments*	\$1,320
Coinsurance	\$330
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,060</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,350
■ <a href="#">Specialist</a> Copayment	\$25
■ Hospital (facility) Copayment*	\$150
■ 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>\$2,010</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$1,350
Copayments*	\$220
Coinsurance	\$280
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,850</b>