
 **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:
What is the overall <a href="#">deductible</a> ?	\$1,500/individual or \$4,500/family; \$1,200/individual or \$3,;; \$900/individual or \$2,700/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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> is 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?	Yes. \$100/individual <a href="#">prescription drug coverage</a> .	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.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For IHP <a href="#">Network</a> \$3,000 individual / \$9,000 family; for <a href="#">prescription drug coverage</a> \$2,000 individual / \$3,000 family.	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="#">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.	Even though you pay these expenses, they don't 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.integrisk.com/ihp">www.integrisk.com/ihp</a> for a list of <a href="#">network providers</a> .	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 <a href="#">plan's 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 <a href="#">provider's</a> 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit	Not covered	None.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit	Not covered	Chiropractic care: 50% <a href="#">coinsurance</a> with a \$750 annual maximum.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	Not covered	None.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not covered	None.
If you need drugs to treat your illness or condition 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	
	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](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)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	Not covered	None.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	Not covered	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required within 48 hours of hospital admission. 50% penalty for no authorization.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Air ambulance is limited to one/year.
	<a href="#">Urgent care</a>	\$25 <a href="#">copay</a>	\$25 <a href="#">copay</a>	For Out of Network Urgent Care, must be in the PHCS Network.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required. 50% penalty for no authorization.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	Not covered	None.
	Inpatient services	10% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> may be required. 50% penalty for no authorization.
If you are pregnant	Office visits	\$25 <a href="#">copay</a>	Not covered	<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> , <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). <a href="#">Preauthorization</a> may be required. 50% penalty for no authorization.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	Not covered	Limited to 100 visits annually. <a href="#">Preauthorization</a> is required. 50% penalty for no authorization.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	Not covered	None.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	Not covered	None.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required. 50% penalty for no authorization.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	None.

[\* 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)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	Not covered	<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	Allowed under PPACA <a href="#">preventive care</a> .
	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"> <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> <li>• Chiropractic care</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> |
|--|---|---|

**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.**

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 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:

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

[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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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>
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**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>
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**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>
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**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>