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, contact IPMG at 1-800-423-1841 or visit our website at www.ipmg.com. 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.www.dol.gov/ebsa/healthreform or https://www.healthcare.gov/sbc-glossary call 1-800-423-1841 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers-$2,000 employee only/ $4,000 employee/dependent/family Out-of-network providers-$4,000 employee only/$8,000 employee/dependent/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. **If Employee/Dependent/Family Coverage, the entire family deductible must be met.**
Are there services covered before you meet your deductible?	Yes. Network Preventive care.	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/.
What is the out-of-pocket limit for this plan?	Coinsurance only: Network providers: $4,000 employee only / $8,000 employee/dependent/family Out-of-network providers: $8,000 employee only/ $16,000 employee/dependent/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. **If Employee/Dependent/Family Coverage – will have a single embedded OOP of $4,000 to a maximum of $8,000 for Network providers** **Combined coinsurance, copayment (medical/PBM), and deductible: Network providers-$7,000 individual/ $14,000 family.** **Out-of-network providers: based on the above excluding copayment-unlimited.**
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.hfninc.com or call 1-800-295-5444 for a list of network providers. Please refer to your ID card.	This plan uses a provider network. You will pay less if you use a provider in the 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.

All 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	15% coinsurance	35% coinsurance	None
	Specialist visit	15% coinsurance	35% coinsurance	None
	Preventive care/screening/ immunization	No charge	$40 copayment Limited to $500 per plan year.	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)	15% coinsurance	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.elixirsolutions.com or at 1-800-771-4648	Generic drugs (Tier 1)	$10 copayment 30 days $25 copayment 90 days	Not covered	Copayment applies AFTER the calendar year deductible. Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail-retail order prescription).
	Preferred brand drugs (Tier 2)	$30 copayment 30 days $75 copayment 90 days	Not covered	
	Non-preferred brand drugs (Tier 3)	$60 copayment 30 days $150 copayment 90 days	Not covered	
	Specialty drugs (Tier 4)	$80 copayment 30 days Mail order is not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Physician/surgeon fees	15% coinsurance	35% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copayment then 15% coinsurance	$250 copayment then 15% coinsurance	Network deductible and out–of–pocket limit applies.
	Emergency medical transportation	15% coinsurance	15% coinsurance	Network deductible and out–of–pocket limit applies.
	Urgent care	15% coinsurance	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	35% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Physician/surgeon fees	15% coinsurance	35% coinsurance	None

[* For more information about limitations and exceptions, see the plan or policy document at www.ipmg.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 need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	35% coinsurance	None
	Inpatient services	15% coinsurance	35% coinsurance	None
If you are pregnant	Office visits	15% coinsurance	35% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	15% coinsurance	35% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	35% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	35% coinsurance	Limited to 120 visits per calendar year.
	Rehabilitation services	15% coinsurance	35% coinsurance	Occupational Therapy
	Habilitation services	15% coinsurance	35% coinsurance	
	Skilled nursing care	15% coinsurance	35% coinsurance	Limited to 60 visits per calendar year.
	Durable medical equipment	15% coinsurance	35% coinsurance	None
	Hospice services	15% coinsurance	35% coinsurance	Limited to $10,000 per person.
If your child needs dental or eye care	Children's eye exam	No charge	35% coinsurance	Children up to age 5.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Glasses
- Hearing aids
- Infertility treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Non-network prescription drugs
- Routine Eye Care
- 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
- Private duty nursing

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

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: the Department of Labor's Employee Benefit 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: IPMG Employee Benefits Services at 1-800-423-1841 or the 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**.
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 [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

*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.ipmg.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	$2000
Specialist copayment	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$2,000
Copayments	$20
Coinsurance	$1,585
What isn't covered	
Limits or exclusions	$15
The total Peg would pay is	**$3,620**

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

The plan's overall deductible	$2000
Specialist copayment	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$2,000
Copayments	$700
Coinsurance	$408
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$3,130**

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

The plan's overall deductible	$2000
Specialist copayment	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$250
Coinsurance	$83
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,333**

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