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, www.myhpnonline.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.healthcare.gov/sbc-glossary or call 1-800-777-1840 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	Not Applicable
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,000/Member and $12,000/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.
What is not included in the out-of-pocket limit?	Penalties for not obtaining any required prior authorization, 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.myhpnonline.com/Member/Doctor-or-Provider or call 1-800-777-1840 for a list of Plan Providers.	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.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		HMO Provider (You will pay the least)	Non-Plan 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	$5 copay/visit	Not Covered	None
	Specialist visit	$10 copay/visit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Preventive care/screening/ immunization	No charge	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $10 copay/service Lab: $5 copay/service	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Imaging (CT/PET scans, MRIs)	$100 copay/service	Not Covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myhpnonline.com	Tier 1	$7 copay/prescription (retail) $17.50 copay/prescription (mail)	Not Covered	You have a 3-Tier pharmacy plan. Covers up to a 30-day retail supply or up to a 90-day mail order supply. Member pays for cost of services if prior authorization or step therapy is not obtained.
	Tier 2	$30 copay/prescription (retail) $75 copay/prescription (mail)	Not Covered	
	Tier 3	$50 copay/prescription (retail) $125 copay/prescription (mail)	Not Covered	
	Tier 4	Not Applicable	Not Applicable	Not Applicable
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay/admit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Physician/surgeon fees	$50 copay/surgery	Not Covered	
If you need immediate medical attention	Emergency room care	ER Physician: No charge ER Facility: $150 copay/visit	ER Physician: No charge ER Facility: $150 copay/visit	You may be balance billed from Non-Plan Providers.
	Emergency medical transportation	$150 copay/trip	$150 copay/trip	
	Urgent care	$20 copay/visit	$20 copay/visit	You may be balance billed from Non-Plan Providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		HMO Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/admit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Physician/surgeon fees	$100 copay/surgery	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay/visit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
	Inpatient services	$300 copay/admit	Not Covered	
If you are pregnant	Office visits	No charge	Not Covered	Routine prenatal care obtained from a Plan Provider is covered at no charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. Lab).
	Childbirth/delivery professional services	$100 copay/admit	Not Covered	Childbirth/delivery professional services includes Anesthesia and Physician Surgical Services. Member pays for cost of services if prior authorization is not obtained.
	Childbirth/delivery facility services	$300 copay/admit	Not Covered	Member pays for cost of services if prior authorization is not obtained.
If you need help recovering or have other special health needs	Home health care	$35 copay/visit	Not Covered	Does not include Specialty Prescription Drugs. Member pays for cost of services if prior authorization is not obtained.
	Rehabilitation services	$5 copay/visit	Not Covered	Coverage is limited to 60 days/visits per year. Member pays for cost of services if prior authorization is not obtained.
	Habilitation services	$5 copay/visit	Not Covered	Coverage is limited to 60 days/visits per year. Member pays for cost of services if prior authorization is not obtained.
	Skilled nursing care	$300 copay/admit	Not Covered	Coverage is limited to 100 days. Member pays for cost of services if prior authorization is not obtained.
	Durable medical equipment	No charge	Not Covered	For purchase or rental at HPN's option. Purchases are limited to a single type of DME, including repair and replacement, every 3 years. Member pays for cost of services if prior authorization is not obtained.
	Hospice services	$300 copay/admit	Not Covered	Member pays for cost of services if prior authorization is not obtained.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		HMO Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	If you elect vision coverage, it will be available under a separate vision plan..
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	If you elect dental coverage, it will be available under a separate dental plan.

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.)

- Abortion (except for rape, incest, life at risk)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult and Child) (available under separate dental plan)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Child) (available under separate vision plan)
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Limited infertility treatment
- Private-duty nursing

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits 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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Nevada Department of Insurance at 888-872-3234 or www.doi.nv.gov or call 1-800-777-1840

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 número de teléfono de servicio al cliente que se incluye en este documento.

Tagalog (Tagalog): Para sa tulong sa Tagalog, tawagan ang numero ng serbisyo sa customer na kabilang sa dokumentong ito.

Chinese (中文): 若需要中文协助，请拨打本文件内的客户服务电话。

Navajo (Dine): Dine k'ehji shich'i' hadoodzih ninizingo, koji' hodiilnih dine yikah 'anidaalwoji ei binumber dii naaltsoos bikaa doo.

––––––––––––––––––––––*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.

(9 months

- The plan's overall deductible $0.00
- Specialist copayment $10.00
- Hospital (facility) copayment $300.00
- Other copayment $100.00

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	$0.00
Copayments	$1,000.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	$1,000.00

- The plan's overall deductible $0.00
- Specialist copayment $10.00
- Hospital (facility) copayment $200.00
- Other copayment $5.00

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$900.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	$900.00

- The plan's overall deductible $0.00
- Specialist copayment $10.00
- Hospital (facility) copayment $200.00
- Other copayment $10.00

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$400.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	$400.00

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

Tiếng Việt (Vietnamese): Quý vị có quyền nhận hỗ trợ và thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu thông dịch viên, hãy gọi số điện thoại được liệt kê trong Tóm tắt quyền lợi và khoản đài thọ (Summary of Benefits and Coverage, SBC) này.

አማርኛ (Amharic):- የለምንም ወጪ እርዳታና መረጃ የማግኘት መብት አለዎት። አስተርጓሚ ለመጠየቅ፣ በዚህ Summary of Benefits and Coverage/የጥቅማጥቅሞችና የሽፋን ማጠቃለያ (SBC) ውስጥ የተዘረዘረውን የቴሌፎን ቁጥር ይደውሉ።

ภาษาไทย (Thai):
คุณมีสิทธิ์รับความช่วยเหลือและข้อมูลเป็นภาษาของคุณเองได้โดยไม่เสียค่าใช้จ่ายใด ๆ ถ้าต้องการล่ามแปล โปรดโทรศัพท์ถึงหมายเลขโทรศัพท์ที่อยู่ในเอกสาร "สาระสำคัญเกี่ยวกับผลประโยชน์และการคุ้มครอง (Summary of Benefits and Coverage หรือ SBC)" นี้

日本語 (Japanese):
ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、本「保障および給付の概要」（Summary of Benefits and Coverage、SBC）に記載されている電話番号にお電話ください。

العربية (**Arabic**): لديك الحق في الحصول على المساعدة بلغتك دون تكلفة. لطلب مترجم، اتصل برقم الهاتف المدرج في موجز المزايا والتغطية هذا (SBC) .

Русский (Russian): Вы вправе получать помощь и информацию на родном языке без дополнительной оплаты. Чтобы заказать услуги переводчика, обращайтесь по номеру, указанному в данном Обзоре льгот и страхового покрытия (Summary of Benefits and Coverage, SBC)

Français (French): Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander l'aide d'un interprète, veuillez appeler le numéro de téléphone figurant dans ce Sommaire des prestations et de la couverture.

فارسی (**Persian**): شما حق دارید که راهنمایی و اطلاعات را به طور رایگان به زبان خودتان دریافت کنید. برای درخواست مترجم شفاهی، با شماره ای که در این خلاصه مزایا و پوشش (SBC) قید شده تماس بگیرید.

Gagana fa'a Sāmoa (Samoan): E iai lau aia tatau e maua ai le fesoasoani ma faamatalaga i lau gagana e aunoa ma se totogi. Ina ia talosaga mo se tagata faaliliu, telefoni i le numera o lisi atu i totonu o lenei Otootoga o Faamanuiaga ma le Kavaina (SBC).

Deutsch (German): Sie haben das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache zu erhalten. Zur Anforderung eines Dolmetschers wenden Sie sich bitte telefonisch an die in dieser Zusammenfassung der Leistungen und des Versicherungsschutzes aufgeführte Rufnummer.

Ilokano (Ilocano): Addaan ka ti karbengan nga makaala iti tulong ken impormasion ayan iti lenguahem nga awan bayad na. Tapno agkiddaw iti tagapataros, awagan ti numero ti telepono nga nakalista iti uneg iti Dagup dagiti Benipisyo ken Pannakasakup (SBC).