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.mpiphp.org. 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 call 1-800-444-6222 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 In-Network $500 Individual / $1,000 Family Out-of-Network	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.
Are there services covered before you meet your deductible?	Yes. In-Network services are covered with no 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.
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?	None In-Network $8,000 Individual / $16,000 Family Out-of-Network	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?	- Premiums - Copayments - Balance-billing charges - Health care this plan does not 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.oxhp.com or call 1-800-444-6222 for a list of network 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).
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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay per visit	30% coinsurance	If you receive services in addition to office visits, additional coinsurance, deductibles, or co-pays may apply.
	Specialist visit	$15 co-pay per visit	30% coinsurance	
	Preventive care/screening/ immunization	No Charge	30% coinsurance	Adults not covered out-of-network. Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance	Pre-Authorization required out-of-network or benefit reduces to 50% of allowed.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	**Retail**: $10 co-pay **Mail Order**: $25 co-pay (90 day supply)	**Retail**: $10 co-pay **Mail Order**: $25 co-pay (90 day supply)	The first two times that you purchase a long-term drug at a participating retail pharmacy, you'll pay your retail co-pay for up to a 30 day supply. After the second purchase at retail, you are required to use mail order or you'll pay the entire cost if you continue to purchase it at retail. If you purchase a brand-name medication when a generic medication is available, you will pay the generic co-payment, plus the difference in cost between the brand and the generic. Prior authorization is required for some medications including compounds and most specialty drugs such as Hepatitis C drugs.
	Preferred brand drugs	**Retail**: $25 co-pay **Mail Order**: $65 co-pay (90 day supply)	**Retail**: $25 co-pay **Mail Order**: $65 co-pay (90 day supply)	
	Non-preferred brand drugs	**Retail**: $40 co-pay **Mail Order**: $100 co-pay (90 day supply)	**Retail**: $40 co-pay **Mail Order**: $100 co-pay (90 day supply)	
	Specialty drugs	**Retail**: $40 co-pay **Mail Order**: $100 co-pay (90 day supply)	**Retail**: $40 co-pay **Mail Order**: $100 co-pay (90 day supply)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance	Pre-Authorization required out-of-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	No Charge	30% coinsurance	
If you need immediate medical attention	Emergency room care	$25 co-pay	$25 co-pay	Waived, if admitted to hospital.
	Emergency medical transportation	No Charge	No Charge	
	Urgent care	$15 co-pay	30% coinsurance	If you receive services in addition to urgent

* For more information about limitations and exceptions, see the plan or policy document at www.mpiphp.org.

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)	
				care, additional co-pays, deductibles or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	30% coinsurance	Pre-Authorization required out-of-network or benefit reduces to 50% of allowed.
	Physician/surgeon fees	No Charge	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 co-pay	30% coinsurance	Pre-Authorization required out-of-network or benefit reduces to 50% of allowed.
	Inpatient services	No Charge	30% coinsurance	
If you are pregnant	Office visits	$15 co-pay per initial visit	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Pre-Authorization required out-of-network or benefit reduces to 50% of allowed.
	Childbirth/delivery professional services	No Charge	30% coinsurance	
	Childbirth/delivery facility services	No Charge	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	$15 co-pay	20% coinsurance	Deductible does not apply. Limited to 60 visits per Contract Year. Pre-Authorization required out-of-network or benefit reduces to 50% of allowed.
	Rehabilitation services	$15 co-pay per outpatient visit	30% coinsurance	Limited to 90 visits per condition, per lifetime. Pre-Authorization required out-of-network or benefit reduces to 50% of allowed.
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	No Charge	30% coinsurance	Pre-Authorization required out-of-network or benefit reduces to 50% of allowed.
	Durable medical equipment	No Charge	30% coinsurance	Pre-Authorization required for items over $500. Pre-Authorization required out-of-network or benefit reduces to 50% of allowed.
	Hospice services	No Charge	30% coinsurance	Limited to 210 days per lifetime (combined inpatient, outpatient and home hospice). At approved facilities only. Inpatient Pre-Authorization required out-of-network or benefit reduces to 50% of allowed.
If your child needs dental or eye care	Children's eye exam (VSP Vision Services) 1-800-877-7195	$20 co-pay Exam once per year	$20 co-pay plus up to $40 once per year	Exam covered only once per year. Eye exams required by an employer and medical or surgical treatment of eyes is covered under the

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)	
				MPI Health Plan.
	Children's glasses	$20 co-pay Frames covered up to $145 Lenses - $0	Frames covered up to $55 Single vision lenses – covered up to $40	Lenses covered only once per year and frames once every two years. Corrective eyewear required by an employer and replacement lenses or frames not covered.
	Children's dental check-up (Delta Dental PPO) 1-800-335-8227	0% of allowable rate for PPO; 20% of allowable rate for Premier PPO; $25 annual deductible per person; up to a $50 maximum per family	50% of UCR rates; $25 annual deductible per person; up to a $50 maximum per family (out-of-network deductible is combined with in-network deductible)	Maximum of $2,000 per person per calendar year
	Children's dental check-up (Delta Dental USA – CA only) 1-800-422-4234	0% / No deductible	No benefit	

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
- Acupuncture
- Routine foot care
- Weight Loss Programs
- Habilitation Services
- Private-duty nursing
- Long-term care

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

- Bariatric Surgery (with limitations)
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Hearing Aids (with limitations)
- Dental Care (Adult)
- Abortion (with limitations)
- Infertility Treatment (with limitations)
- Routine Eye Care (Adult)

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 at 866-444-EBSA (3272) or www.askebsa.dol.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

* For more information about limitations and exceptions, see the plan or policy document at www.mpiphp.org.

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: 1-800-444-6222 or visit us at www.oxhp.com.

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 http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.]

———————————*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 plan's overall deductible	$0
Specialist *co-pay*	$15
Hospital (facility) *coinsurance*	0%
Other *coinsurance*	0%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$15
Coinsurance	$0
What isn't covered	
Limits or exclusions	$250
The total Peg would pay is	$265

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

The plan's overall deductible	$0
Specialist *co-pay*	$15
Hospital (facility) *coinsurance*	0%
Other *coinsurance*	0%

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
Copayments	$330
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	$530

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

The plan's overall deductible	$0
Specialist *co-pay*	$15
Emergency Room *co-pay*	$25
Hospital (facility) *coinsurance*	0%

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
Copayments	$145
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Mia would pay is	$245

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