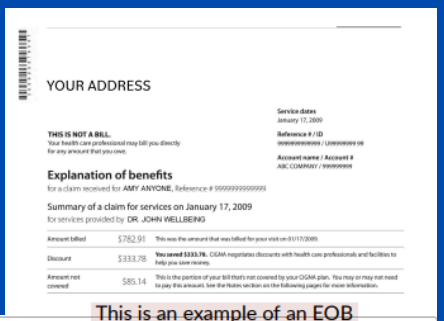
ACTIVE MEDICAL REIMBURSEMENT

Premiums	MEMBER REIMBURSEMENT Free up to 4 dependents	UPGRADED REIMBURSEMENT Member - $20.02 Family - $32.12
Annual Max Per Person	$1,500	$2,500
Inpatient Hosptial Admission	$250	$500
Daily Hospital Benefit	$50 (3 day wait with 7-day max)	$250 (1 day wait with 3-day max)
Emergency Room	$75	$200
Urgent Care	Up to $30 ($180 max)	Up to $100 ($600 max)
Ambulance	$50	$100
Hospital Outpatient	$100	$200
Office Visits	$20 per visit ($100 max)	$35 per visit ($245 max) *Includes E-Visits*
Prescriptions	$20 per prescription ($160 max)	$45 per prescription ($360 max)
Flu Shot	$20	$20
Advanced Radiology	--------	$50 per visit ($100 max)
Specialist Visits	--------	$65 per visit ($260 max) *Includes E-Visits*
Out-of-Network Well Woman	--------	$50
Glasses/Contacts	--------	$100 per year
Gunshot/Critical Laceration	$1,000 (Member only)	$1,000 (Member only)

As of January 1, 2024, all claims must be filed within 180 days from the date of service. It is the member's responsibility to inform HPBT of dependent and marital changes. Note per person and up to copay limits apply to each category. Benefit changes for Urgent Care effective January 1, 2025. Benefit changes for Office Visit & E-Visits under the Upgraded Reimbursement effective May 1, 2025. As of August 15, 2025, any member in Phase Down C or D who sustains a gunshot/critical laceration while taking any action to prevent a crime or is targeted for being a retired police officer while in Phase Down may be entitled to receive a $1,000 gunshot/critical laceration check. Restrictions apply. See Policy for details.

COPAY REIMBURSEMENT CLAIMS FAQ

1. Find your Explanation of Benefits (EOB) from your primary insurance online or call the 1-800 number on the back of your primary insurance card for an insurance representative to help you find your EOB online or mail a printed copy to you. Ask your pharmacy for a prescription print-out.
2. Fill out a medical reimbursement claim form and attach the form to your Explanation of Benefits and/or pharmacy print-out.
3. Submit your claim in person at the HPOU or email to claims@hpbt.us. You can also mail them to 1600 State St., Houston, TX 77007.
4. An Explanation of Payment and/or reimbursement check from HSR will be mailed to your address on file.
5. Questions or concerns? Call (832) 200-3410 or email info@hpbt.us.


YOUR ADDRESS

THIS IS NOT A BILL.
Your health care professional may bill you directly for any amount that you owe.

Service dates: January 17, 2009

Reference # / ID: 999999999999 / 1099999999 99

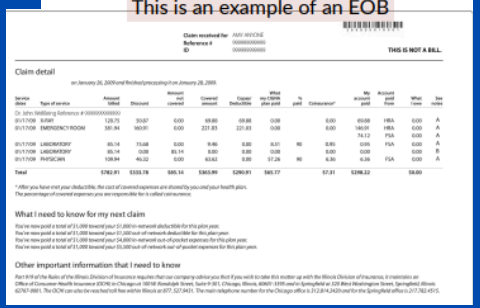
Account name / Account #: ABC COMPANY / 999999999

Explanation of benefits
for a claim received for AMY ANYONE. Reference # 999999999999

Summary of a claim for services on January 17, 2009
for services provided by DR. JOHN WELLBEING

Amount billed	$782.91	This was the amount that was billed for your visit on 01/17/2009.
Discount	$333.78	You saved $333.78. CIGNA negotiates discounts with health care professionals and facilities to help you save money.
Amount not covered	$85.14	This is the portion of your bill that's not covered by your CIGNA plan. You may or may not need to pay this amount. See the Notes section on the following pages for more information.

This is an example of an EOB


Claim received for: AMY ANYONE
Reference #: 999999999999
ID: 999999999999

THIS IS NOT A BILL.

Claim detail
on January 26, 2009 and finalized processing on January 28, 2009.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Covered amount	Copay/ Deductible	What my CIGNA plan paid	% paid	Coinsurance*	My account paid	Account paid from	What I owe	See notes
Dr. John Wellbeing Reference # 999999999999													
01/17/09	X-RAY	128.75	50.67	0.00	69.88	69.88	0.00		0.00	69.88	HRA	0.00	A
01/17/09	EMERGENCY ROOM	581.84	160.01	0.00	221.83	221.83	0.00		0.00	146.01	HRA	0.00	A
										74.12	FSA	0.00	A
01/17/09	L4630R/R3RV	85.14	73.68	0.00	9.46	0.00	9.01	90	0.85	0.85	FSA	0.00	A
01/17/09	L4630R/R3RV	85.14	0.00	85.14	0.00	0.00	0.00		0.00	0.00	FSA	0.00	B
01/17/09	PHYSICIAN	109.94	46.22	0.00	63.62	0.00	57.26	90	6.36	6.36	FSA	0.00	A
Total		$782.91	$333.78	$85.14	$365.99	$290.91	$65.77		$7.31	$298.22		$0.00	

* After you have met your deductible, the cost of covered expenses are shared by you and your health plan. The percentage of covered expenses you are responsible for is called coinsurance.

What I need to know for my next claim

You've now paid a total of $1,000 toward your $1,000 in-network deductible for this plan year.
You've now paid a total of $1,000 toward your $1,000 out-of-network deductible for this plan year.
You've now paid a total of $1,000 toward your $4,000 in-network out-of-pocket expenses for this plan year.
You've now paid a total of $1,000 toward your $5,000 out-of-network out-of-pocket expenses for this plan year.

Other important information that I need to know

Part 50 of the Rules of the Illinois Division of Insurance requires that we complain advise you that if you wish to take this matter up with the Illinois Division of Insurance, it maintains an Office of Consumer Health Insurance (OCHI) in Chicago at 100 W. Randolph Street, Suite 9-301, Chicago, Illinois, 60601-3395 and in Springfield at 320 West Washington Street, Springfield, Illinois, 62767-0001. The OCHI can also be reached toll free within Illinois at 877.527.9431. The main telephone number for the Chicago office is 312.814.2420 and for the Springfield office is 217.782.4515.

HOUSTON POLICE BENEFIT TRUST

Effective August 15, 2025