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 premiums) 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, **call 1-844-260-9900 or visit us at www.hpitpa.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 https://www.healthcare.gov/sbc-glossary/ or call 1-844-260-9900 to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$500 / person $1,500 / family	$1,500 / person $4,500 / 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.
Are there services covered before you meet your deductible?	Yes. Most In-Network office visits, preventive care, and prescription drugs.		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/.
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?	$2,000 / person $4,000 / family	$5,000 / person $10,000 / 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?	Premiums, balance billing, health care this plan doesn't cover, and penalties for failure to meet certain plan requirements.		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.hpitpa.com or call 1-844-260-9900 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). 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?	No		You can see the specialist you choose without a referral.

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	$35 co-pay	50% co-insurance	Deductible does not apply to co-pay. Co-insurance applies after deductible.
	Specialist visit	$50 co-pay	50% co-insurance	Deductible does not apply to co-pay. Co-insurance applies after deductible.
	Preventive care/screening/ Immunization	No charge	50% co-insurance	Deductible does not apply In-Network. Co-insurance applies after deductible. 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) - Lab - X-Ray	No charge up to $500, then 10% co-insurance 10% co-insurance	No charge up to $500, then 10% co-insurance 50% co-insurance	Deductible does not apply up to $500. Co-insurance applies after In-Network deductible.
	Imaging (CT/PET scans, MRIs)	10% co-insurance	50% co-insurance	Co-insurance applies after deductible. Precertification required*
Prescription Drug Benefits				
Common Medical Event	**Services You May Need**	**Retail Pharmacy (30-day supply)**	**Mail Order (90-day supply)**	**Limitations, Exceptions, & Other Important Information**
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hpitpa.com	Generic	$10 co-pay	$20 co-pay	Deductible does not apply to co-pay. FDA approved contraceptives, certain smoking cessation products, and over-the-counter preventive medications (with prescription) are covered at 100%.
	Preferred Brand	$40 co-pay	$80 co-pay	
	Non-Preferred Brand	$75 co-pay	$150 co-pay	
	Specialty	25% co-pay ($50 minimum, $150 maximum)		Deductible does not apply to co-pay. Each amount covers up to a 30-day supply. Certain drugs must be purchased and dispensed by the Plan's Specialty Pharmacy program. Contact Prescription Drug administrator at telephone number on ID Card for more information. These drugs will not be covered by the Medical Plan.

* For more information about limitations and exceptions, see the plan document at **www.hpitpa.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% co-insurance	50% co-insurance	Co-insurance applies after deductible. Charges for other services may apply, such as for anesthesia.
	Physician/surgeon fees	10% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you need immediate medical attention	Emergency room care - Emergency Facility - Non-Emergency Facility - Physician	$200 co-pay, then 10% co-insurance $300 co-pay, then 10% co-insurance 10% co-insurance	$200 co-pay, then 10% co-insurance $300 co-pay, then 10% co-insurance 10% co-insurance	Deductible does not apply to co-pay or Physician. Co-pay is waived if admitted directly to the hospital. Co-insurance applies after In-Network deductible.
	Emergency medical transportation	10% co-insurance	10% co-insurance	Co-insurance applies after In-Network deductible.
	Urgent care	$40 co-pay	$40 co-pay	Deductible does not apply to co-pay.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	50% co-insurance	Co-insurance applies after deductible. Charges for other services may apply, such as for anesthesia or diagnostic tests. Precertification required*
	Physician/surgeon fees	10% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you need mental health, behavioral health, or substance abuse services	Outpatient services - Facility - Physician	10% co-insurance $35 co-pay	50% co-insurance 50% co-insurance	Deductible does not apply to co-pay. Co-insurance applies after deductible.
	Inpatient services	10% co-insurance	50% co-insurance	Co-insurance applies after deductible. Precertification required*
If you are pregnant	Office visits	10% co-insurance	50% co-insurance	Co-insurance applies after deductible. The appropriate Primary Care or Specialist benefit will be applied to the initial visit to confirm pregnancy. There is no charge for In-Network prenatal office visits when billed independently by the physician.*
	Childbirth/delivery	10% co-insurance	50% co-insurance	Co-insurance applies after deductible. Professional services are

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	professional services			generally included in the global fee charged by the physician for pregnancy and delivery.
	Childbirth/delivery facility services	10% co-insurance	50% co-insurance	Co-insurance applies after deductible. Includes birthing centers.
If you need help recovering or have other special health needs	Home health care	10% co-insurance	10% co-insurance	Co-insurance applies after In-Network deductible.
	Rehabilitation services	10% co-insurance	50% co-insurance	Co-insurance applies after deductible. Includes cardiac therapy, chemotherapy, and radiation.
	Habilitation services	10% co-insurance	10% co-insurance	Co-insurance applies after In-Network deductible. Speech therapy, physical therapy, and occupational therapy are limited to 30 visits each per benefit year.
	Skilled nursing care	10% co-insurance	10% co-insurance	Co-insurance applies after In-Network deductible.
	Durable medical equipment	10% co-insurance	10% co-insurance	Co-insurance applies after In-Network deductible.
	Hospice services	10% co-insurance	10% co-insurance	Co-insurance applies after In-Network deductible.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage.
	Children's glasses	Not covered	Not covered	No coverage.
	Children's dental check-up	Not covered	Not covered	No coverage.

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 (Adult)
- Hearing aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss program

* For more information about limitations and exceptions, see the plan document at www.hpitpa.com

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 document at **www.hpitpa.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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, ext. 61565 or www.cciio.cms.gov. For more information on how to continue coverage under this Plan, you may contact the Plan at 1-844-260-9900. 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or the Claims Administrator, at 1-844-260-9900 or at www.hpitpa.com. Additionally, a consumer assistance program can help you file your appeal: contact Health Insurance Smart NC at 1-855-408-1212 or at http://www.ncdoi.com/Smart/.

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 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 1-844-260-9900.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-260-9900

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-260-9900

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-260-9900

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** **$500**
- **Specialist co-pay** **$50**
- **Hospital (facility) co-insurance** **10%**
- **Other co-insurance** **10%**

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	$500
Copayments	$10
Co-insurance	$1,100
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,610**

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

- **The plan's overall deductible** **$500**
- **Specialist co-pay** **$50**
- **Hospital (facility) co-insurance** **10%**
- **Other co-insurance** **10%**

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	$500
Copayments	$800
Co-insurance	$40
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,340**

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

- **The plan's overall deductible** **$500**
- **Specialist co-pay** **$50**
- **Hospital (facility) co-insurance** **10%**
- **Other ER co-pay/co-insurance** **$200/10%**

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	$500
Copayments	$300
Co-insurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-260-9900.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-260-9900.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電844-260-9900.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-260-9900.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-260-9900 번으로 전화해 주십시오.

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العربية **(Arabic):**
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم 1-844-260-9900

Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-260-9900.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-260-9900.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-260-9900.

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો મન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-260-9900.

ខ្មែរ (Mon-Khmer Cambodian): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 844-260-9900 ។

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-260-9900.

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ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-260-9900.

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-260-9900 まで、お電話にてご連絡くださ