



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 1-800-795-1023 or visit us at www.medcost.com. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-795-1023 to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	\$2,000 / person \$4,000 / family	\$4,000 / person \$8,000 / 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: 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 co-payment or co-insurance 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?	\$6,600 / person \$6,600 / family	\$13,200 / person \$13,200 / 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.medcost.com or call 1-800-795-1023 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 **co-payment** and **co-insurance** costs shown in this chart are as noted, *either before or 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	\$30 <u>co-pay</u>	30% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-insurance</u> applies after <u>deductible</u> .
	Specialist visit	\$60 <u>co-pay</u>	30% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-insurance</u> applies after <u>deductible</u> .
	Preventive care/screening/Immunization	No charge	30% <u>co-insurance</u>	<u>Deductible</u> does not apply In-Network. <u>Co-insurance</u> applies after <u>deductible</u> . You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
	Imaging (CT/PET scans, MRIs)	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . <u>Precertification</u> required.*

Prescription Drug Benefits

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Standard Pharmacy (30-day supply)	First Choice Pharmacy Mail Order (30-day supply)	First Choice Pharmacy Mail Order (90-day supply)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medcost.com	Generic drugs	\$17 <u>co-pay</u>	\$10 <u>co-pay</u>	\$25 <u>co-pay</u>	<u>Deductible</u> does not apply to <u>co-pay</u> .
	Preferred brand drugs	\$42 <u>co-pay</u>	\$35 <u>co-pay</u>	\$87.50 <u>co-pay</u>	FDA approved contraceptives, certain smoking cessation products, and over-the-counter preventive medications (with prescription), are covered at 100%.
	Non-preferred brand drugs	\$57 <u>co-pay</u>	\$50 <u>co-pay</u>	\$125 <u>co-pay</u>	
	Specialty drugs	\$250 <u>co-pay</u>			<u>Deductible</u> does not apply to <u>co-pay</u> . Each <u>co-pay</u> covers a 30-day supply. Certain <u>drugs</u> may be purchased and dispensed by the Plan's Specialty Pharmacy program. Contact the <u>Prescription Drug</u> administrator at the telephone number on ID Card for more information. These drugs will not be covered by the Medical <u>Plan</u> .

* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.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)	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Charges for other services may apply, such as for anesthesia.
	Physician/Surgeon	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
If you need immediate medical attention	<u>Emergency room care</u>	\$350 <u>co-pay</u> , then 20% <u>co-insurance</u>	\$350 <u>co-pay</u> , then 20% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-insurance</u> applies after <u>In-Network deductible</u> . <u>Co-pay</u> waived if admitted directly from the emergency room.
	<u>Emergency medical transportation</u>	20% <u>co-insurance</u>	20% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>In-Network deductible</u> .
	<u>Urgent care</u>	\$75 <u>co-pay</u>	30% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-insurance</u> applies after <u>deductible</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Charges for other services may apply, such as for anesthesia or diagnostic tests. <u>Precertification</u> required.*
	Physician/surgeon fees	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services - Facility - Physician - Office Visit	20% <u>co-insurance</u> 20% <u>co-insurance</u> \$30 <u>co-pay</u>	30% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-insurance</u> applies after <u>deductible</u> .
	Inpatient services - Facility - Physician	20% <u>co-insurance</u> 20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . <u>Precertification</u> required.*
If you are pregnant	Office visits	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . The appropriate <u>Primary Care</u> or <u>Specialist</u> benefit will be applied to the initial visit to confirm pregnancy. There is no charge for <u>In-Network</u> prenatal visits when billed independently by the physician.*
	Childbirth/delivery professional services	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Professional services are generally included in the global fee charged by the physician for pregnancy and delivery.
	Childbirth/delivery facility services	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Includes birthing centers.

* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.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 help recovering or have other special health needs	<u>Home health care</u>	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
	<u>Rehabilitation services</u>	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Includes cardiac therapy, chemotherapy, and rehabilitation.
	<u>Habilitation services</u>	\$60 <u>co-pay</u>	30% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-insurance</u> applies after <u>deductible</u> . Chiropractic care, physical therapy, and occupational therapy are limited to combined 30 visits per benefit year. Speech therapy is limited to 30 visits per benefit year.
	<u>Skilled nursing care</u>	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Benefits limited to 60 days per benefit year.
	<u>Durable medical equipment</u>	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
	<u>Hospice services</u>	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
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.)		
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery 	<ul style="list-style-type: none"> Long-term care Dental care (Adult/Children) 	<ul style="list-style-type: none"> Routine eye care (Adult) 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.)		
<ul style="list-style-type: none"> Bariatric surgery Chiropractic care 	<ul style="list-style-type: none"> Hearing aids Infertility treatment 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Private duty nursing

* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.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 704-227-1164. 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, MedCost Benefit Services at 1-800-795-1023 or at www.medcost.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 1-800-795-1023

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-795-1023

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-795-1023

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-795-1023

—————*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 co-insurance) 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 <u>deductible</u>	\$2,000
■ <u>Specialist co-pay</u>	\$60
■ <u>Hospital (facility) co-insurance</u>	20%
■ Other: <u>co-insurance</u>	20%

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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$10
<u>Co-insurance</u>	\$1,900
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,910

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$2,000
■ <u>Specialist co-pay</u>	\$60
■ <u>Hospital (facility) co-insurance</u>	20%
■ Other: <u>co-insurance</u>	20%

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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,100
<u>Copayments</u>	\$900
<u>Co-insurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,000

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$2,000
■ <u>Specialist co-pay</u>	\$60
■ <u>Hospital (facility) co-insurance</u>	20%
■ Other: ER <u>co-pay/co-insurance</u>	\$350/20%

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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$400
<u>Co-insurance</u>	\$10
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,410

English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-795-1023

Español (Spanish):

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-795-1023

한국어 (Korean):

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-795-1023 번으로 전화해 주십시오.

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 1-800-795-1023

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 1-800-795-1023

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك 1023-795-800-1 والاتصال برقم والبيكم الصم ه بالمجان.

Tagalog (Tagalog – Filipino):

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-795-1023

فارسی (Farsi):

وجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-795-1023 تماس بگیرید.

አማርኛ (Amharic):

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዙዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-795-1023 (መስማት ለተሳናቸው)።

کال اردو (Urdu):

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں 1023-795-800-1 کریں دستیاب ہیں۔

Français (French):

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-795-1023

Русский (Russian):

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-795-1023

हिंदी (Hindi):

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-795-1023 पर कॉल करें।

Deutsch (German):

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-795-1023

বাংলা (Bengali):

লক্ষ্য করুনঃ যিদ আপিন বাংলা, কথা বলেত পােরন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেববা উপলব্ধ আছ। েফান করন 1-800-795-1023

Bàsɔ̀̀-wùdù-po-nyò (Bassa):

ɔɛ nià ke dyéɔ́é gbo: ɔ jũ ké m̄ [Bàsɔ̀̀-wùdù-po-nyò] jũ ní, níí, à wuɔ́ kà kò dò po-poò béin m̄ gbo kpáa. ɔ́á 1-800-795-1023

Igbo asusu (Ibo):

Ọ bụrụ na asụ Ibo, asụsụ aka ọasụ n'efu, defu, aka. Call 1-800-795-1023

èdè Yorùbá (Yoruba):

AKIYESI: Bi o ba nsọ èdè Yorùbú ọfẹ ni iranlọwọ lori èdè wa fun yin o. Ẹ pe ẹrọ-ibanisọrọ yi 1-800-795-1023