



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 1-888-590-3152 or visit us at www.medicost.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 1-888-590-3152 to request a copy.

Important Questions	Answers		Why This Matters:
	In- Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$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 <u>plan begins</u> to pay. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan begins</u> to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes: In-network preventive care.		This <u>plan</u> covers some items and services even if you haven't yet met the deductible amount. But a <u>co-payment</u> or <u>co-insurance</u> may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	\$6,900 / person \$13,800 / family	\$12,000 / person \$24,000 / family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance billing</u> , health care this <u>plan</u> doesn't cover, and penalties for failure to meet certain <u>plan requirements</u> .		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.medicost.com or call 1-888-590-3152 for a list of <u>network providers</u>		This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan pays</u> (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No		You can see the <u>specialist</u> you choose without a <u>referral</u> .

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146. Released on April 6, 2016

All 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
		In-Network Provider (You pay more)	Out-of-Network Provider* (You pay most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
	<u>Specialist visit</u>	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
	Preventive care/screening/ Immunization	No charge	50% <u>co-insurance</u>	<u>Deductible</u> does not apply <u>In-Network</u> . <u>Co-insurance</u> applies after <u>deductible</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
	Imaging (CT/PET scans, MRIs)	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Precertification required.*

* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.com.

		Prescription Drugs	
		Retail / Mail Order	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medcost.com .	Preventive Medications	\$0 <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>In-Network deductible</u> . <u>Co-insurance</u> covers up to a 30 day supply (retail prescription). Mail Order shown here covers 90 day supply. FDA approved contraceptives, certain smoking cessation products, and over-the-counter preventive medications (with prescription) are covered at 100%. There is no coverage at Non-Network pharmacies.
	Generic drugs	10% <u>co-insurance</u> Retail 10% <u>co-insurance</u> Mail Order	
	Preferred brand Drugs	30% <u>co-insurance</u> Retail 30% <u>co-insurance</u> Mail Order	
	Non-preferred brand drugs	50% <u>co-insurance</u> Retail 50% <u>co-insurance</u> Mail Order	
	Specialty drugs	30% <u>co-insurance</u>	
		<u>In-Network deductible</u> shared with the medical plan applies; <u>co-insurance</u> applies after deductible. <u>Co-insurance</u> covers a 30 day supply. Certain high cost specialty injectable drugs must be purchased and dispensed by the Plan's Specialty Pharmacy program. Contact the Prescription Drug administrator at the telephone number on the ID Card for more information. These drugs will not be covered by the Medical Plan. Refer to your Summary Plan Description for additional details.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay more)	Out-of-Network Provider* (You pay most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Charges for other services may apply, such as for anesthesia. Precertification required.*
	Physician/surgeon fees	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
If you need immediate medical attention	<u>Emergency Room Care</u>			
	-Emergency	20% <u>co-insurance</u>	20% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>In-Network deductible</u> .
	-Non-Emergency	30% <u>co-insurance</u>	30% <u>co-insurance</u>	
	-Physician	10% <u>co-insurance</u>	10% <u>co-insurance</u>	
	Emergency medical transportation	10% <u>co-insurance</u>	10% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>In-Network deductible</u> . * Pre-certification required for Air Ambulance transports* .
	<u>Urgent care</u>	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after deductible. Charges for other services may apply, such as for lab or x-ray.
	-Minute Clinic	10% <u>co-insurance</u>	50% <u>co-insurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay more)	Out-of-Network Provider* (You pay most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>co-insurance</u>	50% <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.
	Physician/surgeon fees	10% <u>co-insurance</u>	50% <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	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
	- Physician	10% <u>co-insurance</u>	50% <u>co-insurance</u>	
	Inpatient services	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Precertification required. *
If you are pregnant	Office visits	10% <u>co-insurance</u>	50% <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 or In-Network prenatal visits when billed independently by the <u>physician</u> . <u>Co-insurance</u> applies after <u>deductible</u> .
	Childbirth/delivery professional services	10% <u>co-insurance</u>	50% <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 <u>physician</u> for pregnancy and delivery.
	Childbirth/delivery facility services	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Includes birthing centers.

Common Medical Event	Services You May Need	In-Network Provider (You pay more)	Out-of-Network Provider* (You pay most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>co-insurance</u>	50% <u>co-insurance</u>	Co-insurance applies after <u>deductible</u> .
	Rehabilitation services	10% <u>co-insurance</u>	50% <u>co-insurance</u>	Co-insurance applies after <u>deductible</u> . Includes Cardiac Rehabilitation Therapies.
	<u>Habilitation services</u>	10% <u>co-insurance</u>	50% <u>co-insurance</u>	Co-insurance applies after <u>deductible</u> . Includes Physical, Occupational, and Speech therapies. Limited to 30 visits/benefit year for each type of therapy.
	Skilled nursing care	10% <u>co-insurance</u>	50% <u>co-insurance</u>	Co-insurance applies after <u>deductible</u> .
	<u>Durable medical equipment</u>	10% <u>co-insurance</u>	50% <u>co-insurance</u>	Co-insurance applies after <u>deductible</u> .
	Hospice services	10% <u>co-insurance</u>	50% <u>co-insurance</u>	Co-insurance applies after <u>deductible</u> .

If your child needs dental or eye care	Children's eye exam	No coverage	No coverage	No coverage.
	Children's glasses	No coverage	No coverage	No coverage.
	Children's dental check-up	No coverage	No coverage	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 <u>excluded services</u> .)		
- Acupuncture - Bariatric surgery - Cosmetic surgery	- Dental care (Adult) - Infertility treatment - Long-term care - Hearing Aids	- Non-emergency care when traveling outside the U.S - 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 <u>plan document</u> .)		
- Chiropractic Care - Private Duty Nursing		

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 (828)590-3152. 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 (888)-590-3152 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 1-888-590-3152

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-590-3152

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-590-3152

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-590-3152

_____To see examples of how this plan might cover costs for a sample medical situation, see the next section.

11.10.2021

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 **\$2,000**
- Specialist co-insurance **10%**
- Hospital (facility) coinsurance **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*)
Prescription drugs
Specialist visit (*anesthesia*)

Total Example Cost **\$12,700**

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,100
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,100

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible **\$2,000**
- Specialist co-insurance **10%**
- 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	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,800

Mia's Simple Fracture

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

- The plan's overall deductible **\$2,000**
- Specialist insurance **10%**
- Hospital (facility) co-insurance **10%**
- Other: ER co-insurance **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**

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$80
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,080

Note: These numbers assume the patient/member does not participate in the plan's prenatal or chronic condition management programs. If you participate in such programs, you may be able to receive incentives or certain benefits at no cost. For more information about these programs, contact the plan at 1-888-590-3152.

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

English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-590-3152.

Español (Spanish):

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-590-3152.

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1-877-275-2718。

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 1-888-590-3152

한국어 (Korean):

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-275-2718 번으로 전화해 주십시오.

Français (French):

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-590-3152.

العربية (Arabic): ملحوظة: إذا كنت تتحدث أذكر اللغة، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 1-888-590-3152.

Hmoob (Hmong):

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-590-3152.

Русский (Russian):

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-590-3152.

Tagalog (Tagalog – Filipino):

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-590-3152.

ગુજરાતી (Gujarati):

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-590-3152.

ខ្មែរ (Mon-Khmer Cambodian):

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, អ្នកអាចទទួលបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ តេឡេហ្វូន 1-888-590-3152

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-590-3152.

हिंदी (Hindi):

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-590-3152. पर कॉल करें।

ພາສາລາວ (Lao):

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-275-2718.

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。1-888-590-3152 まで、お電話に