

 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 1-800-204-2085 or visit us at www.medcost.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 1-800-204-2085 to request a copy.

Important Questions	Answers				Why This Matters:
	Value Network	Preferred Network	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$800 / person \$1,600 / family	\$800 / person \$1,600 / family	\$800 / person \$1,600 / family	\$4,000 / person \$8,000 / family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Most <u>In-Network</u> office visits, <u>preventive care</u> , and <u>prescription drugs</u> .				This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> 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 <u>plan</u> ?	\$4,000 / person \$8,000 / family	\$4,000 / person \$8,000 / family	\$4,000 / person \$8,000 / family	\$8,000 / person \$16,000 / 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</u> requirements.				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 <u>network provider</u> ?	Yes. See www.medcost.com or call 1-800-204-2085 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 plan's <u>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</u> pays (<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> .



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
		Value Network	Preferred Network	In-Network	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>co-pay</u>	\$25 <u>co-pay</u>	\$30 <u>co-pay</u>	50% <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	\$40 <u>co-pay</u>	\$45 <u>co-pay</u>	\$50 <u>co-pay</u>	50% <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	No charge	No charge	Not covered	<u>Deductible</u> does not apply for Value, Preferred, and <u>In-Network</u> . No coverage for <u>Out-of-Network</u> .
If you have a test	Diagnostic test (x-ray, blood work)	15% <u>co-insurance</u>	25% <u>co-insurance</u>	30% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
	Imaging (CT/PET scans, MRIs)	15% <u>co-insurance</u>	25% <u>co-insurance</u>	30% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Atrium Health and Atrium Wake Forest Baptist Rx Retail Pharmacies (30 day supply)	Community Retail Pharmacies (30 day supply)	CarolinaCARE Mail Service (30 day supply)	CarolinaCARE Mail Service (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	Atrium Health Preventive	\$6 <u>co-pay</u>	\$20 <u>co-pay</u>	\$6 <u>co-pay</u>	\$15 <u>co-pay</u>	<u>Deductible</u> does not apply to <u>co-pay</u> .
	Generic brand drugs	\$10 <u>co-pay</u>	\$20 <u>co-pay</u>	\$10 <u>co-pay</u>	\$25 <u>co-pay</u>	FDA approved contraceptives, smoking cessation products, and certain over-the-counter <u>preventive</u> medications (with prescription) are covered 100%. Refer to the ACA Preventive List available from the pharmacy administrator (www.carolinacarerx.org or 866-697-6800).
	Preferred brand drugs	\$35 <u>co-pay</u>	\$45 <u>co-pay</u>	\$35 <u>co-pay</u>	\$87.50 <u>co-pay</u>	
	Non-preferred brand drugs	\$80 <u>co-pay</u>	\$110 <u>co-pay</u>	\$80 <u>co-pay</u>	\$200 <u>co-pay</u>	
	Specialty drugs	Not Applicable	Not Applicable	\$150 <u>co-pay</u>	Not Applicable	Each <u>co-pay</u> covers a 30 day supply. Refer to the Atrium Specialty Pharmacy List. Specialty <u>drugs</u> must be purchased at CarolinaCARE. Some exceptions may apply to limited distribution <u>drugs</u> and certain infertility <u>drugs</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 or by visiting <https://teammates.atriumhealth.org>.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Value Network	Preferred Network	In-Network	Out-of-Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>co-insurance</u>	25% <u>co-insurance</u>	30% <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.
	Physician/surgeon fees	15% <u>co-insurance</u>	25% <u>co-insurance</u>	30% <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>	\$175 <u>co-pay</u> then 15% <u>co-insurance</u>	\$175 <u>co-pay</u> then 25% <u>co-insurance</u>	\$175 <u>co-pay</u> then 25% <u>co-insurance</u>	\$175 <u>co-pay</u> then 25% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> or <u>co-insurance</u> . <u>Co-pay</u> waived if admitted directly from the <u>emergency room</u> .
	<u>Emergency medical transportation</u>	15% <u>co-insurance</u>	25% <u>co-insurance</u>	25% <u>co-insurance</u>	25% <u>co-insurance</u>	<u>Co-insurance</u> applies after Value <u>Network deductible</u> for Value <u>Network</u> providers. <u>Co-insurance</u> applies after <u>In-Network deductible</u> for the Preferred <u>Network</u> , <u>In-Network</u> , and <u>Out-of-Network</u> providers.
	<u>Urgent care</u> - Facility - Office	15% <u>co-insurance</u> \$70 <u>co-pay</u>	25% <u>co-insurance</u> \$70 <u>co-pay</u>	25% <u>co-insurance</u> \$70 <u>co-pay</u>	50% <u>co-insurance</u> 50% <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)	15% <u>co-insurance</u>	25% <u>co-insurance</u>	30% <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. <u>Precertification</u> required.
	Physician/surgeon fees	15% <u>co-insurance</u>	25% <u>co-insurance</u>	30% <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	15% <u>co-insurance</u>	25% <u>co-insurance</u>	30% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-insurance</u> applies after <u>deductible</u> .
	- Physician	\$20 <u>co-pay</u>	\$25 <u>co-pay</u>	\$30 <u>co-pay</u>	50% <u>co-insurance</u>	
	Inpatient services	15% <u>co-insurance</u>	25% <u>co-insurance</u>	30% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . <u>Precertification</u> required.
If you are pregnant	Office visits	15% <u>co-insurance</u>	25% <u>co-insurance</u>	30% <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 Value, Preferred, and <u>In-Network</u> prenatal visits when billed independently by the physician.
	Childbirth/delivery professional services	15% <u>co-insurance</u>	25% <u>co-insurance</u>	30% <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 physician for pregnancy and delivery.
	Childbirth/delivery facility	15% <u>co-insurance</u>	25% <u>co-insurance</u>	30% <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	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Value Network	Preferred Network	In-Network	Out-of-Network	
If you need help recovering or have other special health needs	Home health care	15% co-insurance	25% co-insurance	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Rehabilitation services	15% co-insurance	25% co-insurance	30% co-insurance	50% co-insurance	Coinurance applies after deductible. Cardiac therapy is limited to 90 visits limit per benefit year.
	Habilitation services	15% co-insurance	25% co-insurance	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Physical therapy is limited to 30 visits per benefit year. Occupational therapy and speech therapy are limited to 20 visits each per benefit year. Respiratory therapy and pulmonary therapy are limited to 50 visits each per benefit year. Developmental disability therapy with a 130 visits limit.
	Skilled nursing care	15% co-insurance	25% co-insurance	25% co-insurance	50% co-insurance	Co-insurance applies after deductible. Co-insurance applies after the In-Network deductible for service performed at Preferred Network and In-Network facility. Limited to 100 days per benefit year.
	Durable medical equipment	Not Applicable	25% co-insurance	25% co-insurance	50% co-insurance	Co-insurance applies after the In-Network deductible for Preferred Network and In-Network providers. Co-insurance applies after out-of-network deductible for out-of-network providers.
	Hospice services	15% co-insurance	25% co-insurance	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If your child needs dental or eye care	Children’s eye exam	Not covered	Not covered	Not covered	Not covered	No coverage.
	Children’s glasses	Not covered	Not covered	Not covered	Not covered	No coverage.
	Children’s dental check-up	Not covered	Not covered	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">• Cosmetic surgery• Dental care (Adult)	<ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S.	<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">• Acupuncture• Bariatric surgery• Chiropractic care	<ul style="list-style-type: none">• Hearing aids• Infertility treatment	<ul style="list-style-type: none">• 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, For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.com or by visiting <https://teammates.atriumhealth.org>.

ext. 61565 or www.ccio.cms.gov. For more information on how to continue coverage under this Plan, you may contact the Plan at 704-631-1500 option 1. 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 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 \$800
- Specialist co-pay \$45
- Hospital (facility) co-insurance 25%
- Other: co-insurance 25%

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	
Deductibles	\$800
Copayments	\$10
Co-insurance	\$2,700
What isn’t covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,510

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

- The plan’s overall deductible \$800
- Specialist co-pay \$45
- Hospital (facility) co-insurance 25%
- Other: co-insurance 25%

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	
Deductibles	\$800
Copayments	\$700
Co-insurance	\$60
What isn’t covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,560

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

- The plan’s overall deductible \$800
- Specialist co-pay \$45
- Hospital (facility) co-insurance 25%
- Other: ER co-pay and co-insurance \$175 then 25%

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	
Deductibles	\$800
Copayments	\$300
Co-insurance	\$400
What isn’t covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

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.

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.

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.

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

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

العربية (Arabic):

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

Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-795-1023.

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

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.

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-795-1023.

ខ្មែរ (Mon-Khmer Cambodian): ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ (800) 795-1023 ។

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

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

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-795-1023.

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。1-800-795-1023 まで、お電話にてご連絡ください