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, 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 1-800-204-2085 to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$1,600 / person $3,200 / 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: Preventive care		This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment 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?	$4,000 / person $8,000 / family	$12,000 / person $24,000 / 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 expenses 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 1-800-204-2085 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
		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	25% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Specialist visit	25% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Preventive care/screening/ Immunization	No charge	Not Covered	Deductible does not apply for In-Network. No coverage Out-of-Network.
If you have a test	Diagnostic test (x-ray, blood work)	25% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Imaging (CT/PET scans, MRIs)	25% co-insurance	50% co-insurance	Co-insurance applies after deductible.

Prescription Drug Benefits						
Common Medical Event	**Services You May Need**	**Atrium Health and Atrium Wake Forest Baptist Rx Retail Pharmacies (30 day supply)**	**Community Retail Pharmacies (30-day supply)**	**Mail Order CarolinaCARE (30day supply)**	**Mail Order Carolina CARE (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.medcost.com	Atrium Health Preventive	$6	$20	$6	$15	Deductible does not apply to Atrium Health Preventive. The cost-share applies after the In-Network deductible for generic, preferred and non-preferred brand drugs. FDA approved contraceptives, smoking cessation products, and certain over-the-counter preventive medications (with prescription) are covered 100%. Refer to the ACA Preventive List available from the pharmacy administrator (www.carolinacarerx.org or 866-697-6800).
	Generic brand drugs	$10	$20	$10	$25	
	Preferred brand drugs	$35	$45	$35	$87.50	
	Non-preferred brand drugs	$80	$110	$80	$200	
	Specialty drugs	Not Applicable	Not Applicable	$150	Not Applicable	The cost-share applies after the In-Network deductible. Each amount covers a 30 day supply. Refer to the Atrium Specialty Pharmacy List. Specialty drugs must be purchased at CarolinaCARE. Some exceptions may apply to limited distribution drugs and certain infertility drugs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network	Out-of-Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% co-insurance	50% co-insurance	Co-insurance applies after deductible. Charges for other services may apply, such as for anesthesia.
	Physician/surgeon fees	25% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you need immediate medical attention	Emergency room care	25% co-insurance	25% co-insurance	Co-insurance applies after In-Network deductible.
	Emergency medical transportation	25% co-insurance	25% co-insurance	Co-insurance applies after In-Network deductible.
	Urgent care	25% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% 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	25% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Inpatient services	25% co-insurance	50% co-insurance	Co-insurance applies after deductible. Precertification required.
If you are pregnant	Office visits	25% 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 Value, Preferred, and In-Network prenatal visits when billed independently by the physician.
	Childbirth/delivery professional services	25% co-insurance	50% co-insurance	Co-insurance applies after deductible. Professional services are generally included in the global fee charged by the physician for pregnancy and delivery.
	Childbirth/delivery facility services	25% co-insurance	50% co-insurance	Co-insurance applies after deductible. Includes birthing centers.
	Home health care	25% co-insurance	50% co-insurance	Co-insurance applies after deductible.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network	Out-of-Network	
If you need help recovering or have other special health needs	Rehabilitation services	25% co-insurance	50% co-insurance	Co-insurance applies after deductible. Cardiac therapy is limited to 90 visits limit per benefit year.
	Habilitation services	25% 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	25% co-insurance	50% co-insurance	Co-insurance applies after deductible. Limited to 100 days per benefit year.
	Durable medical equipment	25% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Hospice services	25% 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	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.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- 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 plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- 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 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 1-800-204-2085 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 1-800-204-2085

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-204-2085

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-204-2085

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-204-2085

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

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, co-payments 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	**$1,600**
Specialist co-insurance	**25%**
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$10
Co-insurance	$2,400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,010**

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

The plan's overall deductible	**$1,600**
Specialist co-insurance	**25%**
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$500
Co-insurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,300**

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

The plan's overall deductible	**$1,600**
Specialist co-insurance	**25%**
Hospital (facility) co-insurance	**25%**
Other: ER co-insurance	**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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Co-payments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,910**

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-204-2085.

Español (Spanish):
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-204-2085.

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1-800-204-2085.

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 1-800-204-2085.

한국어 (Korean):
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-204-2085.번으로 전화해 주십시오.

Français (French):
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-204-2085.

العربية (Arabic): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-204-2085.

Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-204-2085.

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-204-2085.

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-204-2085.

ગુજરાતી (Gujarati):
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-204-2085.

ខ្មែរ (Mon-Khmer Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-204-2085.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-204-2085.

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-204-2085. पर कॉल करें।

ພາສາລາວ (Lao):
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-204-2085.

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。1-800-204-2085. まで、お電話に