**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 | Non-Network | |
| **What is the overall deductible?** | $1,400 / person<br>$2,800 / family | $1,400 / person<br>$2,800 / family | $1,400 / person<br>$2,800 / family | $4,000 / person<br>$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, the overall family deductible must be met before the plan begins to pay. |
| **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 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | $6,000 / person<br>$10,000 / family | $6,000 / person<br>$10,000 / family | $6,000 / person<br>$10,000 / family | $12,000 / person<br>$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 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. |

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

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 | Non-Network | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 15% co-insurance | 25% co-insurance | 30% co-insurance | 50% co-insurance | Co-insurance applies after deductible. |
| | Specialist visit | 15% co-insurance | 25% co-insurance | 30% co-insurance | 50% co-insurance | Co-insurance applies after deductible. |
| | Preventive care/screening/ Immunization | No charge | No charge | No charge | Not covered | Deductible does not apply for Value, Preferred, and In-Network. No coverage for Non-Network. |
| **If you have a test** | Diagnostic test (x-ray, blood work)<br>- Facility/Outpatient<br>- Independent Lab and X-Ray | 15% co-insurance<br>15% co-insurance | 25% co-insurance<br>25% co-insurance | 30% co-insurance<br>25% co-insurance | 50% co-insurance<br>50% co-insurance | Co-insurance applies after deductible. |
| | Imaging (CT/PET scans, MRIs)<br>- Facility/Outpatient<br>- Independent | 15% co-insurance<br>15% co-insurance | 25% co-insurance<br>25% co-insurance | 30% co-insurance<br>25% co-insurance | 50% co-insurance<br>50% co-insurance | Co-insurance applies after deductible. Precertification required. |

| Common Medical Event | Services You May Need | What You Will Pay | | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|---|
| | | Atrium Health 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**<br><br>More information about **prescription drug coverage** is available at www.medcost.com. | Atrium Health Preventive | $6 | $20 | $6 | $15 | 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 | The In-Network deductible must be met before the cost-share amounts apply. The In-Network deductible is shared with the medical plan deductible. |
| | Preferred brand drugs | $35 | $45 | $35 | $87.50 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Non-preferred brand drugs | $100 | $110 | $100 | $250 | |
| | Specialty drugs | $150 | Not Applicable | $150 | Not Applicable | Covers a 30 day supply. Refer to the Atrium Specialty Pharmacy List. Specialty drugs required at CarolinaCARE. Some exceptions may apply to limited distribution drugs and certain infertility drugs. |
| | Important Note for Maintenance Medications | There is one fill at retail maximum for ACA Preventive and Generic Preventive maintenance drugs. When requesting the second fill, the drug must be transferred to CarolinaCARE or the drug will not be covered. All other maintenance drugs can be filled at retail until the deductible is met. Once met, the one fill maximum is applied and must be transferred to CarolinaCARE or the drug will not be covered. Drugs filled at retail after the one fill maximum will not apply to deductibles or annual out-of-pocket limits. | | | | |

| Common Medical Event | Services You May Need | What You Will Pay | | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|---|
| | | Value Network | Preferred Network | In-Network | Non-Network | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% co-insurance | 25% co-insurance | 30% co-insurance | 50% co-insurance | Co-insurance applies after deductible. Charges for other services may apply, such as for anesthesia. |
| | Physician/surgeon fees | 15% co-insurance | 25% co-insurance | 30% co-insurance | 50% co-insurance | Co-insurance applies after deductible. |
| **If you need immediate medical attention** | Emergency room care | 15% co-insurance | 25% co-insurance | 25% co-insurance | 25% co-insurance | Co-insurance applies after the Value Network deductible for the Value tier. Co-insurance applies after In-Network deductible for Preferred Network, In-Network and Non-Network tiers. |
| | Emergency medical transportation | 15% co-insurance | 25% co-insurance | 25% co-insurance | 25% co-insurance | Co-insurance applies after the Value Network deductible for the Value tier. Co-insurance applies after In-Network deductible for Preferred Network, In-Network and Non-Network tiers. |
| | Urgent care (includes Minute Clinic).<br>- Facility<br>- Clinic | <br>15% co-insurance<br>15% co-insurance | <br>25% co-insurance<br>15% co-insurance | <br>25% co-insurance<br>15% co-insurance | <br>50% co-insurance<br>50% co-insurance | Co-insurance applies after deductible. Co-insurance applies after the In-Network deductible for services performed in the office under Value Network, Preferred Network and In-Network. Charges for other services may apply, such as for lab or x-ray. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% co-insurance | 25% co-insurance | 30% 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 | 15% co-insurance | 25% co-insurance | 30% co-insurance | 50% co-insurance | Co-insurance applies after deductible. |

| | | | | | | |
|---|---|---|---|---|---|---|
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 15% co-insurance | 25% co-insurance | 30% co-insurance | 50% co-insurance | Co-insurance applies after deductible. |
| | Inpatient services | 15% co-insurance | 25% co-insurance | 30% co-insurance | 50% co-insurance | Co-insurance applies after deductible. Precertification required. |
| **If you are pregnant** | Office visits | 15% co-insurance | 25% co-insurance | 30% co-insurance | 50% co-insurance | Co-insurance applies after deductible. There is no charge for Value, Preferred, and In-Network prenatal visits when billed independently by the physician. |
| | Childbirth/delivery professional services | 15% co-insurance | 25% co-insurance | 30% 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 | 15% co-insurance | 25% co-insurance | 30% co-insurance | 50% co-insurance | Co-insurance applies after deductible. |
| **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 service | 15% co-insurance | 25% co-insurance | 30% co-insurance | 50% co-insurance | Co-insurance applies after deductible. Includes cardiac with a 90 visits limit. |
| | Habilitation services | 15% co-insurance | 25% co-insurance | 30% co-insurance | 50% co-insurance | Co-insurance applies after deductible. Includes physical therapy with a 30 visits limit, occupational therapy with a 20 visits limit, speech therapy with a 20 visits limit, pulmonary with a 50 visits limit, respiratory with a 50 visits limit, and 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. Limited to 100 visits / benefit year. |
| | Durable medical equipment | Not covered | 25% co-insurance | 25% co-insurance | 50% co-insurance | Co-insurance applies after In-Network deductible for Preferred Network and In-Network tiers. Co-insurance applies after Out-of-Network deductible for the Out-of-Network tier. |
| | 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.) | | |
|---|---|---|
| • Cosmetic surgery<br>• Dental care (Adult) | • Long-term care<br>• Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult)<br>• Routine foot care<br>• Weight loss programs |
| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** | | |
| • Acupuncture<br>• Bariatric surgery<br>• Chiropractic care | • Hearing aids<br>• 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 1-800-795-1023 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, kwiijigo holne' 1-800-795-1023

*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, 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** | **$1,400** |
| **Specialist co-insurance** | **15%** |
| **Hospital (facility) co-insurance** | **15%** |
| **Other: co-insurance** | **15%** |

**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 | $1,400 |
| Copayments | $10 |
| Coinsurance | $1,700 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,110** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,400** |
| **Specialist co-insurance** | **15%** |
| **Hospital (facility) co-insurance** | **15%** |
| **Other: co-insurance** | **15%** |

**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 | $1,400 |
| Copayments | $500 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$2,100** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,400** |
| **Specialist co-insurance** | **15%** |
| **Hospital (facility) co-insurance** | **15%** |
| **Other: co-insurance** | **15%** |

**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 | $1,400 |
| Copayments | $10 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,610** |

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 1-800-795-1023.

**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 1-800-795-1023

**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 નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** 1-800-795-1023.

**ប្រយ័ត្ន៖ (Mon-Khmer Cambodian):** បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-795-1023 ។

**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। 1-800-795-1023 पर कॉल करें।

**ພາສາລາວ (Lao):** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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。