




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, 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 1-800-795-1023 to request a copy.

| Important Questions | Answers | | Why This Matters: |
|---|--|--|--|
| | In-Network | Out-of-Network | |
| What is the overall <u>deductible</u>? | \$3,000 / person \$6,000 / family | \$6,000 / person \$12,000 / 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. <u>Preventive care</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>? | \$7,000 / person \$14,000 / family | \$14,000 / person \$28,000 / 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 1-800-795-1023 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 provider 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 **copayment** and **coinsurance** costs shown in this chart are 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 <u>provider's</u> office or clinic | <u>Primary care</u> visit to treat an injury or illness | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . |
| | <u>Specialist</u> visit | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . |
| | <u>Preventive care/screening/Immunization</u> | No charge | 30% <u>co-insurance</u> | <u>Deductible</u> does not apply <u>In-Network</u> . <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 plan will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . |
| | Imaging (CT/PET scans, MRIs) | 30% <u>co-insurance</u> | 60% <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 | Retail Pharmacy (30-day supply) | Mail Order (90-day supply) | Limitations, Exceptions, & Other Important Information |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.medcost.com | Generic | 30% <u>co-insurance</u> | 30% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>In-Network deductible</u> . FDA approved contraceptives, certain smoking cessation products, and over-the-counter <u>preventive</u> medications (with prescription) are covered at 100%. |
| | Preferred Brand | 30% <u>co-insurance</u> | 30% <u>co-insurance</u> | |
| | Non-Preferred Brand | 30% <u>co-insurance</u> | 30% <u>co-insurance</u> | |
| | Specialty | 30% <u>co-insurance</u> | | <u>Co-insurance</u> applies after <u>In-Network deductible</u> . Each amount covers up to a 30-day supply. Certain <u>drugs</u> must be purchased and dispensed by the <u>Plan's</u> Specialty Pharmacy program. Contact <u>Prescription Drug</u> administrator at telephone number on ID Card for more information. These drugs will not be covered by the Medical Plan. |

* For more information about limitations and exceptions, see the plan document 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) | 30% <u>co-insurance</u> | 60% <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 | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . |
| If you need immediate medical attention | Emergency room care | 30% <u>co-insurance</u> | 30% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>In-Network deductible</u> . |
| | Emergency medical transportation | 30% <u>co-insurance</u> | 30% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>In-Network deductible</u> . |
| | Urgent care | 30% <u>co-insurance</u> | 30% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>In-Network deductible</u> . |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . Charges for other services may apply, such as for anesthesia or <u>diagnostic tests</u> . <u>Precertification</u> required* |
| | Physician/surgeon fees | 30% <u>co-insurance</u> | 60% <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 | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . |
| | Inpatient services | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . <u>Precertification</u> required* |
| If you are pregnant | Office visits | 30% <u>co-insurance</u> | 60% <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 office visits when billed independently by the physician.* |
| | Childbirth/delivery professional services | 30% <u>co-insurance</u> | 60% <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 | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . Includes birthing centers. |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . |
| | <u>Rehabilitation services</u> | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . Includes cardiac therapy, chemotherapy, and radiation. |
| | <u>Habilitation services</u> | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . Chiropractic care, physical |

* For more information about limitations and exceptions, see the plan document 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) | |
| | | | | therapy, and occupational therapy limited to combined 30 visits per benefit year. Speech therapy limited to 30 visits each per benefit year. |
| | Skilled nursing care | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . Limited to 60 days per benefit year. |
| | Durable medical equipment | 30% <u>co-insurance</u> | 60% <u>co-insurance</u> | <u>Co-insurance</u> applies after <u>deductible</u> . |
| | Hospice services | 30% <u>co-insurance</u> | 60% <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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) | | |
|--|---|--|
| <ul style="list-style-type: none"> Acupuncture Cosmetic Surgery | <ul style="list-style-type: none"> Dental care (Adult) 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 program |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> 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"> Private-duty nursing |

* For more information about limitations and exceptions, see the plan document 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 1-800-795-1023. 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 \$3,000
- Specialist co-insurance 30%
- Hospital (facility) co-insurance 30%
- Other co-insurance 30%

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

| | |
|---------------------|---------|
| <u>Deductibles</u> | \$3,000 |
| <u>Copayments</u> | \$0 |
| <u>Co-insurance</u> | \$2,900 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$5,900 |
|-----------------------------------|----------------|

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$3,000
- Specialist co-insurance 30%
- Hospital (facility) co-insurance 30%
- Other co-insurance 30%

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> | \$3,000 |
| <u>Copayments</u> | \$0 |
| <u>Co-insurance</u> | \$700 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$3,700 |
|-----------------------------------|----------------|

Mia's Simple Fracture

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

- The plan's overall deductible \$3,000
- Specialist co-insurance 30%
- Hospital (facility) co-insurance 30%
- Other ER co-insurance 30%

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> | \$2,800 |
| <u>Copayments</u> | \$0 |
| <u>Co-insurance</u> | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|----------------|
| The total Mia would pay is | \$2,800 |
|-----------------------------------|----------------|

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

ខ្មែរ (Mon-Khmer Cambodian): ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតលុយ 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