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	Non-Network	
What is the overall deductible?	$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 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: In-Network office visits, preventive care, and prescription drugs.		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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,000 / person $12,000 / 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 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 1-800-795-1023 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay	50% co-insurance	There is no deductible In-Network. Co-insurance applies after deductible Out-of-Network.
	Specialist visit	$70 co-pay	50% co-insurance	There is no deductible In-Network.
	Preventive care/screening/ Immunization	No charge	Not covered	There is no deductible In-Network. No coverage for Out-of-Network.
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance	50% co-insurance	There is no deductible In-Network. Co-insurance applies after deductible Out-of-Network.
	Imaging (CT/PET scans, MRIs)	30% co-insurance	50% co-insurance	There is no deductible In-Network. Co-insurance applies after deductible Out-of-Network. Precertification required.*

Prescription Drug Benefits					
		Retail Pharmacy 30 day supply	Retail Pharmacy 90 day supply	Mail Order 90 day supply	
If you need drugs to treat your illness or condition	Generic drugs	$10 co-pay	$30 co-pay	$20 co-pay	FDA approved contraceptives, certain smoking cessation products, and over-the-counter preventive medications (with prescription), are covered at 100%. Refer to the Plan Document for details.
	Preferred brand drugs	$85 co-pay	$255 co-pay	$245 co-pay	
	Non-preferred brand drugs	$100 co-pay	$300 co-pay	$290 co-pay	
More information about **prescription drug coverage** is available at www.medcost.com.	Specialty drugs	$10 co-pay Generic $85 co-pay Preferred $100 co-pay Non-Preferred			Each co-pay 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 ID Card for more information. These drugs will not be covered by the Medical Plan.

* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal 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% co-insurance	50% co-insurance	Co-insurance applies after deductible. Charges for other services may apply, such as for anesthesia.
	Physician/surgeon fees	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you need immediate medical attention	Emergency room care	30% co-insurance	30% co-insurance	Co-insurance applies after In-Network deductible.
	Emergency medical transportation	30% co-insurance	30% co-insurance	Co-insurance applies after In-Network deductible.
	Urgent care	$75 co-pay	50% co-insurance	Co-insurance applies after deductible. 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)	$250 co-pay, then 20% co-insurance	$500 co-pay, then 50% co-insurance	Co-insurance applies after deductible Out-of-Network. Charges for other services may apply, such as for anesthesia or diagnostic tests. Precertification required.*
	Physician/surgeon fees	30% co-insurance	50% co-insurance	There is no deductible In-Network. Co-insurance applies after deductible Out-of-Network.
If you need mental health, behavioral health, or substance abuse services	Inpatient Services - Facility - Physician	$250 co-pay then 20% co-insurance 20% co-insurance	$500 co-pay then 50% co-insurance 50% co-insurance	Co-insurance applies after deductible. Precertification required.*
	Outpatient Services - Facility - Physician as any Specialist	30% co-insurance $70 co-pay	50% co-insurance 50% co-insurance	Co-insurance applies after deductible.
If you are pregnant	Office visits - Initial visit - Subsequent visits / global fee	$70 co-pay 20% co-insurance	50% co-insurance 50% co-insurance	Co-insurance applies after deductible. There is no charge for In-Network prenatal visits when billed independently by the physician.*
	Childbirth/delivery professional services	20% 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	$250 co-pay then 20% co-insurance	$500 co-pay then 50% co-insurance	Co-insurance applies after deductible. Includes birthing centers.

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 need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Limited to 40 visits / benefit year.
	Rehabilitation services	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Cardiac therapy limited to 36 outpatient visits per condition.
	Habilitation services	30% co-insurance	50% co-insurance	Co-insurance applies after deductible. Includes physical, occupational, and speech therapies. Limited to 30 visits each/ benefit year for all therapies.
	Skilled nursing care	20% co-insurance	50% co-insurance	Co-insurance applies after deductible. Benefits limited to Benefit Year maximum of 60 days.
	Durable medical equipment	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Hospice services	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	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.)		
• Acupuncture • Bariatric surgery • 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.)		
• Chiropractic care	• Infertility treatment (testing only)	• 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 540-473-8349. 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.

05.21.2021

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-pay	**$70**
Hospital (facility) co-insurance	**20%**
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	
Deductibles	$2,000
Copayments	$300
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,200**

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-pay	**$70**
Hospital (facility) co-insurance	**20%**
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	
Deductibles	$900
Copayments	$1,400
Coinsurance	$
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	**$2,000**
Specialist co-pay	**$70**
Hospital (facility) co-insurance	**20%**
Other: 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	
Deductibles	$2,000
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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

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

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

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

العربية (Arabic):
ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك 1023-795-800-1 والبكم الصم ه بالمجان .اتصل برقم

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

فارسی (Farsi):
وجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-795-1023 تماس بگیرید.

አማርኛ (Amharic):
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-795-1023 (መስማት ለተሳናቸው.

اُردُو کال (Urdu):
خبردار :اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں 1023-795-800-1 کریں دستیاب ہیں -

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

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 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।

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

বাংলা (Bengali):
লা্য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পা◌েরন, তাহেল ি◌নঃখরচায় ভাষা সহায়তা পিরেষবা উপল◌ ◌োছ।
◌েফান করন 1-800-795-1023

Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ (Bassa):
ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 1-800-795-1023

Igbo asusu (Ibo):
Ọ bụrụ na asụ Ibo, asụsụ aka ọasụ n'efu, defu, aka. Call 1-800-795-1023

èdè Yorùbá (Yoruba):
AKIYESI: Bi o ba nsọ èdè Yorùbú ọfé ni iranlọwọ lori èdè wa fun yin o. Ẹ pe ẹrọ-ibanisọrọ yi 1-800-795-1023