



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 1-888-230-6873 or visit us at www.medcost.com/HBT. 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 1-888-230-6873 to request a copy.

Important Questions	Answers		Why This Matters:
	In-Network	Out-of-Network	
What is the overall deductible? **see below	\$3,000 / person \$6,000 / family	\$3,000 / person \$6,000 / 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: <u>preventive care</u>		This plan covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your deductible. See a list of covered <u>preventive services</u> 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?	\$3,000 / person \$6,000 / family	\$3,000 / person \$6,000 / 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 plan, 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 out-of-pocket limit?	<u>Premiums</u> , <u>balance billing</u> , 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 <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.medcost.com/HBT or call 1-888-230-6873 for a list of <u>network providers</u>		This plan 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 plan pays (<u>balance billing</u>). Be aware, your network provider 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 referral to see a specialist?	No		You can see the <u>specialist</u> you choose without a <u>referral</u> .

**This High Deductible Health Plan qualifies for a Health Savings Account from which plan participants may be reimbursed for qualified medical expenses incurred prior to satisfying their deductible.



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	<u>Primary care</u> visit to treat an injury or illness	No charge	No charge	No charge after <u>deductible</u> has been met.
	<u>Specialist</u> visit	No charge	No charge	No charge after <u>deductible</u> has been met.
	<u>Preventive care/screening/immunization</u>	No charge	No charge	<u>Deductible</u> does not apply. Limited to \$500 / benefit year for <u>Out-of-Network</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	No charge	No charge after <u>deductible</u> has been met.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	No charge after <u>deductible</u> has been met. Precertification required.*
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.medcost.com/HBT	Generic drugs	No charge**		**No charge after the deductible that is shared with the medical plan has been met. Covers up to a 30 day supply (retail prescription) or a 90 day supply (mail order prescription). FDA approved contraceptives, certain smoking cessation products, and over-the-counter <u>preventive</u> medications (with prescription) are covered at 100%.
	Preferred brand drugs	No charge**		
	Non-preferred brand drugs	No charge**		
	Specialty drugs	See note under Limitations & Exceptions		Certain high cost <u>specialty injectable drugs</u> must be purchased and dispensed by the Plan's Specialty Pharmacy program. Contact the <u>Prescription Drug</u> administrator at telephone number on the ID Card for more information or refer to the Plan Document.*
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	No charge after <u>deductible</u> has been met. Charges for other services may apply, such as anesthesia.
	Physician/surgeon fees	No charge	No charge	No charge after <u>deductible</u> has been met.
If you need immediate medical attention	<u>Emergency room care</u>			For emergency services, there is no charge after <u>In-Network deductible</u> has been met. For non-emergency services, the <u>In-Network</u> or <u>Out-of-Network deductible</u> must be met before the plan will pay.
	- Emergency services	No charge	No charge	
	- Non-Emergency services	No charge	No charge	
	<u>Emergency medical transportation</u>	No charge	No charge	No charge after <u>deductible</u> has been met.

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)	
	<u>Urgent care</u> - <u>Facility</u> - <u>Physician's office</u>	No charge No charge	No charge No charge	For facility based urgent care, the <u>In-Network</u> or <u>Out-of-Network deductible</u> must be met before the plan will pay. For office based urgent care, there is no charge after <u>In-Network deductible</u> has been met. 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)	No charge	No charge	No charge after <u>deductible</u> has been met. Charges for other services may apply, such as for anesthesia or diagnostic tests. Precertification required.*
	Physician/surgeon fees	No charge	No charge	No charge after <u>deductible</u> has been met.
If you need mental health, behavioral health, or substance abuse services	Outpatient services - Facility - Physician	No charge No charge	No charge No charge	No charge after <u>deductible</u> has been met.
	Inpatient services	No charge	No charge	No charge after <u>deductible</u> has been met. Precertification required.*
If you are pregnant	Office visits - Initial visit - Global fee	No charge No charge	No charge No charge	No charge after <u>deductible</u> has been met. There is no charge for <u>In-Network</u> prenatal visits that are billed independently by the <u>physician</u> .*
	Childbirth/delivery professional services	No charge	No charge	No charge after <u>deductible</u> has been met. Professional services are generally included in the global fee charged by the <u>physician</u> for pregnancy & delivery.
	Childbirth/delivery facility services	No charge	No charge	No charge after <u>deductible</u> has been met. Includes birthing centers.
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	No charge	No charge after <u>deductible</u> has been met. Limited to 16 hours / day. Includes private duty nursing.

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)	
	<u>Rehabilitation services</u>	No charge	No charge	No charge after <u>deductible</u> has been met. Includes cardiac, cognitive and pulmonary therapies.
	<u>Habilitation services</u>	No charge	No charge	No charge after <u>deductible</u> has been met. Includes speech, physical, and occupational therapies.
	<u>Skilled nursing care</u>	No charge	No charge	No charge after <u>deductible</u> has been met. Limited to 100 days / benefit year.
	<u>Durable medical equipment</u>	No charge	No charge	No charge after <u>deductible</u> has been met.
	<u>Hospice services</u>	No charge	No charge	No charge after <u>deductible</u> has been met.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage. Contact your Human Resources Department for possible coverage availability under a separate plan.
	Children's glasses	Not covered	Not covered	No coverage. Contact your Human Resources Department for possible coverage availability under a separate plan.
	Children's dental check-up	Not covered	Not covered	No coverage. Contact your Human Resources Department for possible coverage availability under a separate plan.

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 (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 919-715-9782. 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 1-888-230-6873 or at www.medcost.com/HBT. 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 1-888-230-6873

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-230-6873

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-230-6873

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-230-6873

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

05.04.2021

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 **\$3,000**
- **Specialist** (after deductible) **0%**
- **Hospital (facility)** (after deductible) **0%**
- **Other:** (after deductible) **0%**

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:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3,000

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** (after deductible) **0%**
- **Hospital (facility)** (after deductible) **0%**
- **Other:** (after deductible) **0%**

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:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,000

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

- The plan's overall deductible **\$3,000**
- **Specialist** (after deductible) **0%**
- **Hospital (facility)** (after deductible) **0%**
- **Other:** (after deductible) **0%**

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:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

Note: These numbers assume the patient/member does not participate in the plan's wellness program (such as SmartStarts). If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, contact the plan at 919-715-9782.

English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-230-6873.

Español (Spanish):

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-230-6873.

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1-888-230-6873。

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 1-888-230-6873.

한국어 (Korean):

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-230-6873 번으로 전화해 주십시오.

Français (French):

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-230-6873.

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر
والبكم الصم ه لك بالمجان. اتصل برقم 6873

Hmoob (Hmong):

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-230-6873.

Русский (Russian):

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-230-6873.

Tagalog (Tagalog – Filipino):

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-230-6873.

ગુજરાતી (Gujarati):

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-230-6873.

ខ្មែរ (Mon-Khmer Cambodian):

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-888-230-6873 ។

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-230-6873.

हिंदी (Hindi):

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-230-6873 पर कॉल करें।

ພາສາລາວ (Lao):

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-230-6873.

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。1-888-230-6873 まで、お電話に