




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?	\$15,000 / person \$30,000 / family	\$15,000 / person \$30,000 / 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 deductible?	Yes: Most <u>In-Network</u> office visits, <u>preventive care</u> , and <u>prescription drugs</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 deductibles for specific services?	No		You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$15,350 / person \$30,700 / family	\$15,350 / person \$30,700 / 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 out-of-pocket limit?	<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 network provider?	Yes. See www.medcost.com/HBT or call 1-888-230-6873 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 <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 Plan is accompanied by a Medical Expense Reimbursement Plan (MERP) that contributes toward the overall Deductible. After an Individual pays \$1,750 and a Family pays \$3,500 toward the Deductible, the MERP pays for qualified expenses 80% In-Network and 50% Non-Network (with Plan Participants paying 20% In-Network and 50% Non-Network) until an individual \$7,000 or a family \$14,000 Deductible has been satisfied, then the MERP pays for qualified expenses 100% for an individual \$5,000 or a family 10,000 deductible and the full Deduction has been satisfied.

 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	\$25 <u>co-pay</u>	30% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-insurance</u> applies after <u>deductible</u> .
	Specialist visit	\$50 <u>co-pay</u>	30% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-insurance</u> applies after <u>deductible</u> .
	Preventive care/screening/immunization	No charge	No charge	<u>Deductible</u> does not apply. Benefits are limited to \$500 per benefit year for <u>Out-of-Network</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 <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	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> .
	Imaging (CT/PET scans, MRIs)	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Precertification 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/HBT	Generic drugs	\$10 <u>co-pay</u>	\$30 <u>co-pay</u>	<u>Deductible</u> does not apply to <u>co-pay</u> .
	Preferred brand drugs	50% <u>co-pay</u> (maximum \$100)	50% <u>co-pay</u> (maximum \$300)	FDA approved contraceptives, certain smoking cessation products, and over-the-counter <u>preventive</u> medications (with prescription) are covered at 100%.
	Non-preferred brand drugs	50% <u>co-pay</u> (maximum \$100)	50% <u>co-pay</u> (maximum \$300)	
	Specialty drugs	50% <u>co-pay</u> (maximum \$100)		<u>Deductible</u> does not apply to <u>co-pay</u> . Covers up to 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 <u>Plan</u> .

* For more information about limitations and exceptions, see the plan document at www.medcost.com



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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Charges for other services may apply, such as anesthesia.
	Physician/surgeon fees	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
If you need immediate medical attention	<u>Emergency room care</u>	\$500 <u>co-pay</u>	\$500 <u>co-pay</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-pay</u> is waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>co-insurance</u>	20% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>In-Network deductible</u> .
	<u>Urgent care</u>	\$25 <u>co-pay</u>	\$25 <u>co-pay</u>	<u>Deductible</u> does not apply to <u>co-pay</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Charges for other services may apply, such as for anesthesia or diagnostic tests. Precertification required.*
	Physician/surgeon fees	20% <u>co-insurance</u>	30% <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 - Facility - Physician	20% <u>co-insurance</u> \$50 <u>co-pay</u>	30% <u>co-insurance</u> 30% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-insurance</u> applies after <u>deductible</u> .
	Inpatient services	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Precertification required.*
If you are pregnant	Office visits	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> . 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 visits that are billed independently by the physician.*
	Childbirth/delivery professional services	\$150 <u>co-pay</u>	30% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</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 & delivery.
	Childbirth/delivery facility services	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Includes birthing centers.

* For more information about limitations and exceptions, see the plan document at www.medcost.com



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 need help recovering or have other special health needs	<u>Home health care</u>	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> . Benefits limited to 16 hours per day.
	<u>Rehabilitation services</u>	\$50 <u>co-pay</u>	30% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-insurance</u> applies after <u>deductible</u> . Includes cardiac, cognitive and pulmonary therapies.
	<u>Habilitation services</u>	\$50 <u>co-pay</u>	30% <u>co-insurance</u>	<u>Deductible</u> does not apply to <u>co-pay</u> . <u>Co-insurance</u> applies after <u>deductible</u> . Includes speech, physical, and occupational therapies.
	<u>Skilled nursing care</u>	20% <u>co-insurance</u>	20% <u>co-insurance</u>	<u>Co-insurance</u> applies after In-Network <u>deductible</u> . Benefits limited to 100 days per benefit year.
	<u>Durable medical equipment</u>	20% <u>co-insurance</u>	30% <u>co-insurance</u>	<u>Co-insurance</u> applies after <u>deductible</u> .
	<u>Hospice services</u>	20% <u>co-insurance</u>	30% <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. Contact your Human Resources Department for possible coverage availability.
	Children's glasses	Not covered	Not covered	No coverage. Contact your Human Resources Department for possible coverage availability.
	Children's dental check-up	Not covered	Not covered	No coverage. Contact your Human Resources Department for possible coverage availability.

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.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult/Children) • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult) 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Hearing aids 	<ul style="list-style-type: none"> • 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

* For more information about limitations and exceptions, see the plan document at www.medcost.com

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.

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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 \$15,000
- Specialist co-pay \$50
- Hospital (facility) co-insurance 20%
- Other: co-insurance 20%

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>	
<u>Deductibles</u>	\$7,400
<u>Co-payments</u>	\$200
<u>Co-insurance</u>	\$3,100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$10,700

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

- The plan's overall deductible \$15,000
- Specialist co-pay \$50
- Hospital (facility) co-insurance 20%
- Other: co-insurance 20%

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>	
<u>Deductibles</u>	\$4,200
<u>Co-payments</u>	\$200
<u>Co-insurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$4,400

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

- The plan's overall deductible \$15,000
- Specialist co-pay \$50
- Hospital (facility) co-insurance 20%
- Other: ER co-pay \$550

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>	
<u>Deductibles</u>	\$1,200
<u>Co-payments</u>	\$700
<u>Co-insurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000

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 واليكم الصم ه لك بالمجان. اتصل برقم: 1-888-230-6873

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, សេវាជំនួយផ្នែកភាសាដោយមិនគិតលុយ 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, ໂດຍບໍ່ແຈ້ງຄ່າ, 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