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 premium) 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 1-800-424-3405 or visit www.ncscbf.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-424-3405 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Provider: **$200** Individual / **$600** Family; Out-of-Network Provider: **$400** Individual / **$1,200** 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 this 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. Unless otherwise specified, the following do not count toward the deductible: Preventive care, hospice care, home health care, and skilled nursing facility care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay 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?	Yes. **$25** for Dental Care Benefits for Classes P, S, and T only. There are no other specific deductibles.	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?	Medical: In-Network Provider: **$1,500** Individual / **$4,500** Family; Out-of-Network Provider: **$2,500** Individual / **$7,500** Family. PPRx: **$5,350** Individual / **$9,200** Family.	The out-of-pocket limit ("OOP") 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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Coinsurance reduction of 5% for each non-emergency hospital confinement or inpatient surgical procedure which is not precertified as required; coinsurance for out-of-network preventive care in excess of maximum; amounts in excess of the maximum for out-of-network chiropractic visits; premiums, balance billing charges, and health care this plan does not cover.	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. For a list of network providers, visit: www.anthem.com.	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.

All **copay** 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)	Non-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	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	Chiropractor and acupuncture - In-Network: 10% coinsurance Out-of-Network: 30% coinsurance Chiropractor visits are payable for the treatment of musculoskeletal and neuromusculoskeletal conditions and are limited to $40/visit. Chiropractic care is not payable for infants and dependent children age 5 and under, unless medical necessity is established by a physician, and is payable only for the treatment of documented injuries for dependent children ages 6 to 12, unless medical necessity is established by a physician. Acupuncture is limited to $500/year.
	Preventive care/screening/ immunization for preventive care services prescribed by the Patient Protection and Affordable Care Act of 2010 (PPACA)	No charge	Not covered	None
	Preventive care/screening/ immunization for preventive care services that are not prescribed by the Patient Protection and Affordable Care Act of 2010 (PPACA)	See limitations & exceptions	See limitations & exceptions	Well child care age 2 and over payable in full up to $200/calendar year (excess at 80% coinsurance). Routine physical exams for employee and dependent spouse payable in full up to $531/calendar year (excess at 80% coinsurance), except Preferred Provider Preventive Care Program not limited. Routine colonoscopy and EKGs at 10% coinsurance, no deductible or maximum. Non-covered routine immunizations at 100%.

[*For more information about limitations and exceptions, see the plan or policy document at www.ncscbf.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Preauthorization recommended.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	$8 copay/prescription (retail); $16 copay/prescription (mail order)	Not covered	In-network: Covers up to a 30-day supply (retail); 90-day supply (mail order); 30-day supply (specialty pharmacy). Drugs excluded from the Plan's Formulary are not covered unless approved in advance through a Formulary exception process managed by Express Scripts. Contraceptives covered are those that require a physician's written prescription, except for emergency (Plan B). Smoking cessation products limited to two 90-day supplies per 365-day period.
	Brand name drugs (including multi-source brand name contraceptives)	Greater of $15 or 25% of cost, to maximum of $35/prescription (retail) and greater of $30 or 25% of cost, to maximum of $70/prescription (mail order)		
	Specialty medications (through specialty pharmacy)	25% of cost, to maximum of $50/prescription		
	Generic and single source brand name contraceptives (including oral, emergency, diaphragm, patch, and ring)	No charge (retail and mail order)		
	OTC aspirin, smoking cessation products (including OTC nicotine replacement therapy and federal legend drugs), federal legend fluoride, OTC iron supplements, and OTC folic acid upon a physician's written prescription	No charge (retail and mail order)		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Preauthorization for certain outpatient surgeries/procedures recommended. Preauthorization recommended for prophylactic mastectomies.
If you need immediate medical attention	Emergency room care	$150 copay/visit, then 10% coinsurance	$150 copay/visit, then 10% coinsurance	Copay waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification required for non-emergency hospital stay (and emergency admissions within 48 hours) or additional 5% coinsurance, up to $500 maximum penalty.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Precertification required for non-emergency inpatient surgery (or emergency surgery within 48 hours) or additional 5% coinsurance, up to $500 maximum penalty. Preauthorization recommended for prophylactic mastectomies.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Precertification required for non-emergency hospital stay (and emergency admissions within 48 hours) or additional 5% coinsurance, up to $500 maximum penalty.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Precertification required or additional 5% coinsurance, up to $500 maximum penalty.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None

[*For more information about limitations and exceptions, see the plan or policy document at www.ncscbf.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Preauthorization recommended.
	Rehabilitation services	10% coinsurance	30% coinsurance	Preauthorization recommended for physical therapy and occupational therapy after initial evaluation and 8 sessions. Precertification required for inpatient rehabilitation or additional 5% coinsurance, up to $500 maximum penalty.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	No charge	No charge	Limited to 30 days per period of disability. Precertification required or additional 5% coinsurance, up to $500 maximum penalty.
	Durable medical equipment	10% coinsurance	30% coinsurance	Preauthorization for certain equipment recommended. CPAP, BiPAP, and AutoPAP supplies covered up to $200/year.
	Hospice services	No charge	No charge	Preauthorization recommended for home hospice. Precertification required for hospice care in a hospice facility or additional 5% coinsurance, up to $500 maximum penalty.
If your child needs dental or eye care	Children's eye exam	10% coinsurance	10% coinsurance	No maximum for 1 exam every 2 calendar years, up to age 19. (Classes P, S, and T only.)
	Children's glasses	10% coinsurance	10% coinsurance	Limited to $400 each 2 consecutive calendar year period; then 90% coinsurance. (Classes P, S, and T only.)
	Children's dental check-up	$25 deductible/year, then 10% coinsurance	$25 deductible/year, then 10% coinsurance	Limited to 2 check-ups per year, up to age 19, no maximum. (Classes P, S, and T only.)

[*For more information about limitations and exceptions, see the plan or policy document at www.ncscbf.com.]

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.)

- Bariatric surgery
- Cosmetic surgery, except for the repair or reconstruction of injuries within 12 months of the date of the injury or breast reconstruction following mastectomy
- Habilitation services
- Infertility treatment (only infertility testing covered up to $4,000/lifetime)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs, except physician services, lab work, and patient education in a medical setting for treatment of morbid obesity are covered up to $500/lifetime subject to certain criteria

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture, subject to medical guidelines which specify certain conditions and diagnoses for which acupuncture is recognized to be effective, up to $500/year
- Chiropractic care for treatment of musculoskeletal and neuromusculoskeletal conditions, up to $40/visit
- Dental care, up to $1,200/calendar year and orthodontic are up to $2,000/lifetime (Classes P, S, and T only)
- Hearing aids, limited to one per ear / 3 years, up to $2,000
- Routine eye care (Adult, Classes P, S, and T only)

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 the Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 1-800-424-3405.

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 the Plan Administrator at 1-800-424-3405, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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

[*For more information about limitations and exceptions, see the plan or policy document at www.ncscbf.com.]

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, copays 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	$200
Specialist copay	$0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$11,471**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copays	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,260**

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

The plan's overall deductible	$200
Specialist copay	$0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$6,138**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copays	$703
Coinsurance	$293
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,251**

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

The plan's overall deductible	$200
Specialist copay	$0
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$1,533**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copays	$0
Coinsurance	$193
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$393**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.