




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 <u>deductible</u>?	In-Network Provider: \$1,000 Individual / \$3,000 Family; Out-of-Network Provider: \$2,000 Individual / \$6,000 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 this <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. Unless otherwise specified, the following do not count toward the deductible: <u>Preventive care</u> , hospice care, home health care, and skilled nursing facility care.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</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?	There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Medical: In-Network Provider: \$5,000 Individual / \$10,000 Family; Out-of-Network Provider: \$10,000 Individual / \$30,000 Family. PPRx: \$1,850 Individual / \$3,700 Family.	The <u>out-of-pocket limit</u> ("OOP") 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.

Important Questions	Answers	Why This Matters:
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><u>Coinsurance</u> reduction of 5% for each non-emergency hospital confinement or inpatient surgical procedure which is not precertified as required; <u>coinsurance</u> for <u>out-of-network preventive care</u> in excess of maximum; amounts in excess of the maximum for <u>out-of-network chiropractic visits</u>; <u>premiums</u>, <u>balance billing charges</u>, and health care this <u>plan</u> does not cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket-limit</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. For a list of <u>network providers</u>, visit: www.anthem.com.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's 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.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a referral.</p>

 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	25% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	<u>Specialist</u> visit	25% <u>coinsurance</u>	45% <u>coinsurance</u>	Chiropractor and acupuncture - <u>In-Network</u> : 25% <u>coinsurance</u> <u>Out-of-Network</u> : 45% <u>coinsurance</u> 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.
	<u>Preventive care/screening/immunization</u> for <u>preventive care</u> services prescribed by the Patient Protection and Affordable Care Act of 2010 (PPACA)	No charge	Not covered	None
	<u>Preventive care/screening/immunization</u> for <u>preventive care</u> 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% <u>coinsurance</u>). Routine physical exams for employee and dependent spouse payable in full up to \$531/calendar year (excess at 80% <u>coinsurance</u>), except <u>Preferred Provider Preventive Care</u> Program not limited. Routine colonoscopy and EKGs at 10% <u>coinsurance</u> , no <u>deductible</u> 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	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	45% <u>coinsurance</u>	<u>Preauthorization</u> recommended.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com .	Generic drugs	\$8 <u>copay</u> /prescription (retail); \$16 <u>copay</u> /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 <u>Plan's</u> 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)		
	<u>Specialty medications</u> (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)		

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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)	25% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	Physician/surgeon fees	25% <u>coinsurance</u>	45% <u>coinsurance</u>	<u>Preauthorization</u> for certain outpatient surgeries/procedures recommended.
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay/visit</u> , then 25% <u>coinsurance</u>	\$150 <u>copay/visit</u> , then 25% <u>coinsurance</u>	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	None
	<u>Urgent care</u>	25% <u>coinsurance</u>	45% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	45% <u>coinsurance</u>	Precertification required for non-emergency hospital stay (and emergency admissions within 48 hours) or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty.
	Physician/surgeon fees	25% <u>coinsurance</u>	45% <u>coinsurance</u>	Precertification required for non-emergency inpatient surgery (or emergency surgery within 48 hours) or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty. <u>Preauthorization</u> recommended for prophylactic mastectomies.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% <u>coinsurance</u>	45% <u>coinsurance</u>	None
	Inpatient services	25% <u>coinsurance</u>	45% <u>coinsurance</u>	Precertification required for non-emergency hospital stay (and emergency admissions within 48 hours) or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty.
If you are pregnant	Office visits	25% <u>coinsurance</u>	45% <u>coinsurance</u>	Precertification required or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty.
	Childbirth/delivery professional services	25% <u>coinsurance</u>	45% <u>coinsurance</u>	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	45% <u>coinsurance</u>	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	<u>Home health care</u>	No charge	No charge	<u>Preauthorization</u> recommended.
	<u>Rehabilitation services</u>	25% <u>coinsurance</u>	45% <u>coinsurance</u>	<u>Preauthorization</u> recommended for physical therapy and occupational therapy after initial evaluation and 8 sessions. Precertification required for inpatient rehabilitation or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty.
	<u>Habilitation services</u>	Not covered	Not covered	Not covered
	<u>Skilled nursing care</u>	No charge	No charge	Limited to 30 days per period of disability. Precertification required or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	45% <u>coinsurance</u>	<u>Preauthorization</u> for certain equipment recommended. CPAP, BiPAP, and AutoPAP supplies covered up to \$200/year.
	<u>Hospice services</u>	No charge	No charge	<u>Preauthorization</u> recommended for home hospice. Precertification required for hospice care in a hospice facility or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

[*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
- Dental care (Adult)
- 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 eye care (Adult)
- 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
- Hearing aids, limited to one per ear / 3 years, up to \$2,000

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.—————

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 **\$1,000**
- Specialist copay **\$0**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

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	\$8,493
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copays	\$32
Coinsurance	\$3,149
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,241

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

- The plan's overall deductible **\$1,000**
- Specialist copay **\$0**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

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	\$4,899
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copays	\$703
Coinsurance	\$732
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,490

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

- The plan's overall deductible **\$1,000**
- Specialist copay **\$0**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

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	\$444
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copays	\$0
Coinsurance	\$481
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,481