




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, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/health-care-law-protections/summary-of-benefits-and-coverage/> or call 1-800-424-3405 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<p><u>In-Network Provider</u>: \$200 Individual / \$600 Family; <u>Out-of-Network Provider</u>: \$400 Individual / \$1,200 Family.</p>	<p>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>.</p>
Are there services covered before you meet your <u>deductible</u>?	<p>Yes: LiveHealth Online, <u>preventive care</u>, hospice care, home health care, and skilled nursing facility care.</p>	<p>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.</p>
Are there other <u>deductibles</u> for specific services?	<p>Yes. \$50 every 2 calendar years for Delta Dental Dental Care Benefits. There are no other specific <u>deductibles</u>.</p>	<p>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.</p>
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<p>Medical: <u>In-Network Provider</u>: \$1,500 Individual / \$4,500 Family; <u>Out-of-Network Provider</u>: \$2,500 Individual / \$7,500 Family. <u>Prescription Drugs</u>: \$5,350 Individual / \$9,200 Family.</p>	<p>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 limit</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>
What is not included in the <u>out-of-pocket limit</u>?	<p>Precertification penalties; certain <u>specialty medications</u>, <u>premiums</u>, <u>balance billing</u> charges, 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>
Will you pay less if you use a <u>network provider</u>?	<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>

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral.

 All [copayment](#) 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)	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	10% coinsurance	30% coinsurance	No charge for Anthem LiveHealth Online visit.
	Specialist visit	10% coinsurance	30% coinsurance	Chiropractor visits are payable for the treatment of musculoskeletal and neuromusculoskeletal conditions and are limited to \$40/visit and 26 visits per calendar year. Unless medical necessity is established, chiropractic care is not covered for dependent children age 12 and under, except treatment of documented injuries for dependent children ages 6 to 12 is covered. Acupuncture is limited to \$500/year.
	Preventive care/screening/immunization	No charge for ACA preventive services	Not covered, except as noted	No charge for well child care from birth to age 18 by out-of-network provider . Routine physical exams for employee and dependent spouse by out-of-network provider payable in full up to \$531/calendar year (excess at 80% coinsurance). Routine colonoscopy and EKGs by out-of-network provider covered at 10% coinsurance , no deductible . Certain immunizations by out-of-network provider covered at 100%. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood)	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)	Out-of-Network Provider (You will pay the most)	
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	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> 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	30-day supply: \$8 <u>copay</u> /prescription (retail); 90-day supply: \$16 <u>copay</u> /prescription (Smart-90 retail or mail order)	Not covered	Drugs excluded from the <u>Plan's Formulary</u> are not covered unless approved in advance through a <u>Formulary</u> exception process managed by Express Scripts. No charge for <u>ACA preventive care</u> drugs with a physician's written prescription, except no prescription required for emergency contraceptives (Plan B). Smoking cessation products limited to two 90-day supplies per 365-day period. Maintenance drugs are available at retail for up to a 90-day supply only at a Smart-90 Retail Network pharmacy (currently Walgreens).
	Brand drugs	30-day supply: greater of \$15 or 25% of cost, max of \$35/prescription (retail) 90-day supply: greater of \$30 or 25% of cost, max of \$70/prescription (Smart-90 retail or mail order)	Not covered	
	Specialty drugs	25% of cost, max of \$50/prescription	Not covered	
	Non-select specialty drugs	Amount listed on the SaveOnSP Specialty Drug List	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> for certain outpatient surgeries/procedures recommended.
If you need immediate medical attention	Emergency room care	\$150 <u>copay</u> /visit, then 10% <u>coinsurance</u>	\$150 <u>copay</u> /visit, then 10% <u>coinsurance</u>	<u>Copay</u> waived if admitted.
	Emergency medical transportation	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	Urgent care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None

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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)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <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.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	No charge for Anthem LiveHealth Online visit.
	Inpatient services	10% <u>coinsurance</u>	30% <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	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Precertification required for hospital stay in excess of 48 hours following vaginal delivery or 96 hours following a C-section, or additional 5% <u>coinsurance</u> , up to \$500 maximum penalty. <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	<u>Preauthorization</u> recommended.
	Rehabilitation services	10% <u>coinsurance</u>	30% <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.
	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% <u>coinsurance</u> , up to \$500 maximum penalty.
	Durable medical equipment	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> for certain equipment recommended. CPAP, BiPAP, and AutoPAP supplies covered up to \$400/year.

* 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)	Out-of-Network Provider (You will pay the most)	
	Hospice services	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	No charge	Up to \$50 allowance	1 exam every calendar year (No coverage for Class E)
	Children's glasses	\$350 allowance, then 20% off any balance	Up to \$350 allowance	\$350 allowance applies once every 2 years (No coverage for Class E)
	Children's dental check-up – Delta Dental	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Limited to 2 check-ups per year, up to age 19, no maximum. Not subject to maximum (No coverage for Class E)
	Children's dental check-up – CarePlus Dental	No charge	Not covered	Calendar year maximum does not apply (No coverage for Class E)

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"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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.)		
<ul style="list-style-type: none"> Acupuncture subject to medical guidelines up to \$500/year Chiropractic care up to \$40/visit and 26 visits per calendar year 	<ul style="list-style-type: none"> Dental care with Delta Dental, up to \$2,400 every 2 calendar years and orthodontic up to \$2,000/lifetime (No coverage for Class E) Dental care with CarePlus Dental, up to \$2,000 per calendar year (No coverage for Class E) 	<ul style="list-style-type: none"> Hearing aids, limited to one per ear / 3 years, up to \$2,000 Routine eye care (No coverage for Class E)

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

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 <https://www.dol.gov/agencies/ebsa>. 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 on how 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/agencies/ebsa.

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](#).

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](#), [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](#) \$200
- [Specialist coinsurance](#) 10%
- 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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$0
Coinsurance	\$1,240
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,500

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 coinsurance](#) 10%
- 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$700
Coinsurance	\$170
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,130

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$200
- [Specialist coinsurance](#) 10%
- 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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$150
Coinsurance	\$260
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$610

The Plan offers a Health Reimbursement Account that you can use to pay [deductibles](#), [copays](#) and [coinsurance](#) amounts and other medical expenses that are not covered by the Plan or another source. You may file for reimbursement for some of these expenses, as permitted by the Plan's Health Reimbursement Account.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.