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 1-877-275-2718 or visit us at www.medcost.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/sbc-glossary/ or call 1-877-275-2718 to request a copy.

Important Questions	Answers		Why This Matters:
	Preferred & In-Network	Non-Network+	
What is the overall deductible?	$1,000/employee only $1,250/employee + 1 $2,000/employee + family	$1,500/employee only $2,250/employee + 1 $4,500/employee + 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. The deductible starts over January 1st.
Are there services covered before you meet your deductible?	Yes: Many Preferred and In-Network office visits and certain other services covered with a co-pay and/or Deductible waived; also preventive care, and prescription drugs.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment 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. There are separate deductibles for prescription drugs filled at OptumRx network pharmacies, and for non-preferred brand prescription drugs.**		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. ***See page 3 of this document for detailed information.*
What is the out-of-pocket limit for this plan?	$6,550/employee only $13,100/employee + 1 $13,100/employee + family	$10,000/employee only $15,000/employee + 1 $20,000/employee + family	The out-of-pocket limit 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.
What is not included in the out-of-pocket limit?	Premiums, balance billing, 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 out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.medcost.com or http://www.missionandme.com/ or call 1-877-275-2718 for a list of network providers.		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.

+Non-Network services are only covered if not available In-Network and a gap exception has been approved. This does not apply to emergency care or urgent care facilities.

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
		Preferred Network Mission Health Partners (You pay less)	In-Network Provider (You pay more)	Out-of-Network Provider+ (You pay most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 co-pay	$35 co-pay	No coverage	Deductible does not apply to Preferred or In-Network. Includes lab and x-ray services performed in the office.
	Specialist visit	$50 co-pay	25% co-insurance	No coverage	Deductible does not apply to Preferred. Co-insurance applies after deductible for In-Network. Includes lab and x-ray services performed in the office.
	Preventive care/screening/ Immunization	No charge	No charge	No coverage	Deductible does not apply to Preferred or In-Network.
If you have a test	Diagnostic test (x-ray, blood work) - Lab - X-ray	 No charge $20 co-pay	 25% co-insurance 25% co-insurance	 No coverage No coverage	Deductible does not apply to Preferred for lab and x-ray services. Co-insurance applies after deductible for In-Network.
	Imaging (CT/PET scans, MRIs)	$100 co-pay	25% co-insurance	No coverage	Deductible does not apply to Preferred. Co-insurance applies after deductible. Precertification required.*

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* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.com.

		Mission Pharmacy	Mission Pharmacy Mail Order	OptumRx Network (Mail Order not included)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medcost.com.	Generic drugs	$0 co-pay	$0 co-pay	$0 co-pay	Co-pay or co-insurance shown covers a 30 day supply at Mission Pharmacy or OptumRx Network Pharmacy. Mail order co-pay or co-insurance shown covers a 90 day supply. Member will pay difference in the cost of generic and name brand when name brand is chosen over generic. Mail order medications are available only through a Mission Pharmacy. Insulin and other diabetic medications on the formulary: $25 co-pay for a 30 day supply; $60 co-pay for a 90 day supply. FDA approved contraceptives, certain smoking cessation products, and over-the-counter (OTC) preventive medications (with prescription) are covered at 100%. Limitations may apply to prescription drug classes with OTC alternatives; and to certain diabetic medications; please refer to the Summary Plan Description for details.
	Preferred brand drugs	$40 co-pay	$80 co-pay	$60 co-pay after this *deductible*[1]: $200/employee; $400/employee + 1; $400/employee + family	

[+]Non-Network services are only covered if not available In-Network and a gap exception has been approved. This does not apply to emergency care or urgent care facilities.
* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.com.

		Mission Pharmacy	Mission Pharmacy Mail Order	OptumRx Network (Mail Order not included)	Limitations, Exceptions, & Other Important Information
	Non-preferred brand drugs	50% co-insurance with $100 minimum, $200 maximum (not to exceed the price of the drug) after this *deductible*[2] $500/employee; $1,000/employee+1; $1,000/employee +family	50% co-insurance with $200 minimum, $400 maximum (not to exceed the price of the drug) after this *deductible*[2]: $500/employee; $1,000/employee +1; $1,000/employee +family	60% co-insurance with $100 minimum, $300 maximum (not to exceed the price of the drug) after this *deductible*[2]: $500/employee; $1,000/employee +1; $1,000/employee +family	Mission Pharmacies, nor to plan participants who live outside of North Carolina. **[2]A separate annual deductible also applies to non-preferred brand drugs, as noted in this section.** ***Maintenance Medications:*** Any drug classified as a maintenance medication must be filled as a 3-month supply through Mission Employee Mail Order Pharmacy. Two 30-day prescription fills are allowed prior to 90-day supply fills being required. Plan participants who reside outside of North Carolina can obtain any drug classified as a maintenance medication filled as a 3-month supply from any OptumRx Retail Pharmacy. **There is no coverage at Non-Network pharmacies.**
	Specialty drugs	10% co-insurance ($75 minimum, $150 maximum)	No coverage	No coverage	Co-insurance covers a 30 day supply. No coverage at a pharmacy other than Mission unless referred by a Mission Pharmacy. **There is no coverage at Non-Network pharmacies.**

[+]Non-Network services are only covered if not available In-Network and a gap exception has been approved. This does not apply to emergency care or urgent care facilities.
* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Mission Health Partners (You pay less)	In-Network Provider (You pay more)	Out-of-Network Provider+ (You pay most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) - Hospital – Outpatient Surgery - Ambulatory Surgery Center	25% co-insurance 25% co-insurance	25% co-insurance 25% co-insurance	No coverage No coverage	Deductible does not apply Preferred. Co-insurance applies after deductible. Charges for other services may apply, such as for anesthesia. Precertification required.* Outpatient surgery from Mission-owned facilities and practices: $225 co-pay / visit; deductible does not apply.
	Physician/surgeon fees	25% co-insurance	25% co-insurance	No coverage	Co-insurance applies after deductible.
If you need immediate medical attention	Emergency room care - Emergency services - Non-emergency services	$200 co-pay $300 co-pay	$200 co-pay $300 co-pay	$200 co-pay $300 co-pay	Deductible does not apply to co-pays.
	Emergency medical transportation	25% co-insurance	25% co-insurance	25% co-insurance	Co-insurance applies after deductible. Emergency services with Out-of-Network Providers covered as In-Network+. Precertification required for all non-emergent transports.
	Urgent care	$50 co-pay	$50 co-pay	$100 co-pay	Deductible does not apply. Charges for other services may apply, such as for lab or x-ray.

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* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Mission Health Partners (You pay less)	In-Network Provider (You pay more)	Out-of-Network Provider+ (You pay most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$600 co-pay	25% co-insurance	No coverage	Deductible does not apply to Preferred. Co-insurance applies after deductible. Charges for other services may apply, such as for anesthesia or diagnostic tests. Precertification required.*
	Physician/surgeon fees	25% co-insurance	25% co-insurance	No coverage	Co-insurance applies after deductible.
If you need mental health, behavioral health, or substance abuse services	Outpatient services - Facility - Physician Office Visit	25% co-insurance $35 co-pay	25% co-insurance $35 co-pay	No coverage No coverage	Deductible does not apply to Preferred. Co-insurance applies after deductible. Outpatient services from Mission-owned facilities and practices: $225 co-pay / visit; deductible does not apply.
	Inpatient services	$600 co-pay	25% co-insurance	No coverage	Deductible does not apply to co-pays. Co-insurance applies after deductible. Charges for other services may apply, such as for anesthesia or diagnostic tests. Precertification required.*
If you are pregnant	Office visits - Initial visit - Subsequent visits / global fee	$35 co-pay No charge up to $1,400, then 25% co-insurance	$35 co-pay No charge up to $1,400, then 25% co-insurance	No coverage No coverage	Deductible does not apply to copays. Co-insurance applies after deductible. There is no charge for In-Network prenatal visits when billed independently by the physician. When prenatal services are combined with the global fee, the benefit will be as shown and covered at 100% up to $1,400.*
	Childbirth/delivery professional services	25% co-insurance	25% co-insurance	No coverage	Co-insurance applies after deductible. Professional services are generally included in the global fee charged by the physician for pregnancy and delivery.
	Childbirth/delivery facility services	$600 co-pay	25% co-insurance	No coverage	Deductible does not apply to Preferred. Co-insurance applies after deductible. Includes birthing centers.

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* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Mission Health Partners (You pay less)	In-Network Provider (You pay more)	Out-of-Network Provider+ (You pay most)	
If you need help recovering or have other special health needs	Home health care	25% co-insurance	25% co-insurance	No coverage	Co-insurance applies after deductible. Limited to 3 visits / day.
	Rehabilitation services Cardiac rehabilitation - Outpatient Hospital - Other	 25% co-insurance 25% co-insurance	 25% co-insurance 25% co-insurance	 No coverage No coverage	Only phases 1 and 2 of cardiac rehabilitation are covered. Deductible does not apply to copays. Co-insurance applies after deductible. Outpatient services from Mission-owned facilities and practices: $225 co-pay / visit; deductible does not apply.
	Rehabilitation services Chemo & Radiation - Outpatient Hospital - Other	 25% co-insurance 25% co-insurance	 25% co-insurance 25% co-insurance	 No coverage No coverage	Deductible does not apply to copays. Co-insurance applies after deductible. Outpatient services from Mission-owned facilities and practices: $225 co-pay / visit; deductible does not apply.
	Habilitation services	25% co-insurance	25% co-insurance	No coverage	Co-insurance applies after deductible. Includes ABA, pulmonary, physical, occupational, respiratory, and speech therapies. Prior authorization is required.* Limited to 30 visits / benefit year for each type of therapy, except ABA therapy is limited to 140 visits / benefit year. Additional visits may be available with prior authorization. Physical therapy from Mission Health providers: $20 co-pay / visit; deductible does not apply.
	Skilled nursing care	25% co-insurance	25% co-insurance	No coverage	Co-insurance applies after deductible. Coverage is for a skilled nursing *facility.* Prior authorization is required.*

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* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Mission Health Partners (You pay less)	In-Network Provider (You pay more)	Out-of-Network Provider+ (You pay most)	
	Durable medical equipment	25% co-insurance	25% co-insurance	No coverage	Co-insurance applies after deductible. Prior authorization required.*
	Hospice services	25% co-insurance	25% co-insurance	No coverage	Co-insurance applies after deductible.
If your child needs dental or eye care	Children's eye exam	No coverage	No coverage	No coverage	No coverage. Coverage is available under a separate election / different plan. This does not apply to vision screening performed by a pediatrician as covered under preventive care.
	Children's glasses	No coverage	No coverage	No coverage	No coverage. Coverage is available under a separate election / different plan.
	Children's dental check-up	No coverage	No coverage	No coverage	No coverage. Coverage is available under a separate election / different 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 (accident services and orthognathic surgery are covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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

- Acupuncture (limited to 24 visits / benefit year)
- Bariatric surgery (covered only at certain facilities & subject to certain plan limitations)
- Chiropractic care (limited to 24 visits / benefit year)
- Hearing aids (limited to $5,000 every 3 calendar years)
- Infertility treatment (testing; treatment for underlying medical condition only)
- Private duty nursing (prior authorization required)
- Routine foot care (only when associated with diabetes and peripheral vascular disease)
- Weight loss programs (through Mission Weight Management Program)

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* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.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 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 828-213-5600. 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 1-877-275-2718 or at www.medcost.com. 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 1-877-275-2718
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-275-2718
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-275-2718
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-275-2718

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

09.04.2020

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* For more information about limitations and exceptions, refer to the Plan Document which can be accessed via the Member Portal at www.medcost.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, 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** **$1,000**
- **Specialist co-pay** **$35**
- **Hospital (facility) coinsurance (MHP)** **$600**
- **Other: co-insurance (MHP)** **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)*
Prescription drugs
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$656
Coinsurance	$2
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,654**

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 co-pay** **$50**
- **Hospital (facility) co-insurance (MHP)** **25%**
- **Other: co-insurance (MHP)** **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$540
Coinsurance	$182
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,722**

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

- **The plan's overall deductible** **$1,000**
- **Specialist co-pay** **$50**
- **Hospital (facility) co-insurance (MHP)** **25%**
- **Other: ER co-pay (MHP)** **$200**

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,008
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,208**

Note: These numbers assume the patient/member does not participate in the plan's prenatal or chronic condition management programs. If you participate in such programs, you may be able to receive incentives or certain benefits at no cost. For more information about these programs, contact the plan at 1-828-213-2222.

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

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (877) 275-2718.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (877) 275-2718.

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 (877) 275-2718.

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 (877) 275-2718.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (877) 275-2718 번으로 전화해 주십시오.

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (877) 275-2718.

العربية (Arabic): ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم)877 (275-2718 :والبكم الصم ه

Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (877) 275-2718.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (877) 275-2718.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (877) 275-2718.

ગુજરાતી (Gujarati): **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** (877) 275-2718.

ប្រយ័ត្ន៖ **(Mon-Khmer Cambodian):** បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-795-1023 ។

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (877) 275-2718.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (877) 275-2718 पर कॉल करें।

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານ ພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (877) 275-2718.

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。(877) 275-2718 まで、お電話にてご連絡ください。