This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.firstcarolinacare.com or by calling 1-800-811-3298.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1000 individual / $3000 family for participating providers $2000 individual /$6000 family for non-participating providers Does not apply to preventive care, office visits and prescription drugs. Coinsurance and copays do not count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers $3500 person / $7000 family For non-participating providers $6000 person / $12000 family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, copays, no precert penalties, balance-billed charges, and health services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.firstcarolinacare.com or call 1-800-811-3298	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay / visit	Deductible and 30% coinsurance	----------none----------
	Specialist visit	$35 copay / visit	Deductible and 30% coinsurance	----------none----------
	Other practitioner office visit	$25 copay / visit for chiropractor	Deductible and 30% coinsurance for chiropractor	Chiropractic benefits limited to 12 visits per year
	Preventive care/screening/immunization	No Charge	Deductible and 30% coinsurance	Preventive services covered at no cost are defined by federal law and are subject to change
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Deductible and 40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	Deductible and 20% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at www.firstcarolinacare.com**	Generic drugs	$8 copay / prescription for 30 day supply $24 copay / prescription for 90 day supply	$28 copay / prescription for 30 day supply $84 copay / prescription for 90 day supply	Certain medications may require prior authorization, step therapy or have quantity limits
	Preferred brand drugs	$35 copay / prescription for 30 day supply $105 copay / prescription for 90 day supply	$70 copay / prescription for 30 day supply $210 copay / prescription for 90 day supply	Certain medications may require prior authorization, step therapy or have quantity limits
	Non-preferred brand drugs	$55 copay / prescription for 30 day supply $165 copay / prescription for 90 day supply	$110 copay / prescription for 30 day supply $330 copay / prescription for 90 day supply	Certain medications may require prior authorization, step therapy or have quantity limits

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible and 20% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP
	Physician/surgeon fees	Deductible and 20% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP
If you need immediate medical attention	Emergency room services	$150 copay and 20% coinsurance / visit (hospital copayment waived if admitted) $35 copay for physician	$150 copay and 20% coinsurance / visit (hospital copayment waived if admitted) $35 copay for physician	----------none----------
	Emergency medical transportation	Deductible and 20% coinsurance	Deductible and 20% coinsurance	----------none----------
	Urgent care	$75 copay / visit	$75 copay / visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible and 20% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP. In network cost applies if admitted for emergency medical attention.
	Physician/surgeon fee	Deductible and 20% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP. In network cost applies if admitted for emergency medical attention.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 office visit / other outpatient services Deductible and 20% coinsurance	Deductible and 30% coinsurance / office visit. Other outpatient services Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP.
	Mental/Behavioral health inpatient services	Deductible and 20% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP.
	Substance use disorder outpatient services	$25 office visit / other outpatient services Deductible and 20% coinsurance	Deductible and 30% coinsurance / office visit. Other outpatient services Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP.
	Substance use disorder inpatient services	Deductible and 20% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$25 for 1st prenatal visit only	Deductible and 30% coinsurance	----------none----------
	Delivery and all inpatient services	Deductible and 20% coinsurance	Deductible and 40% coinsurance	In network cost applies if admitted for emergency medical attention
If you need help recovering or have other special health needs	Home health care	$25 copay / visit	Deductible and 30% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP. Home Health Care benefits limited to 30 visits per year
	Rehabilitation services	Outpatient: $25 copay/visits 1-6, Deductible and 20% coinsurance/visits 7-60 Inpatient: Deductible and 20% coinsurance	Outpatient: Deductible and 30% coinsurance Inpatient: Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP. Outpatient physical, speech or occupational therapy is limited to 60 visits per year. Inpatient physical, speech or occupational therapy is limited to 45 days.
	Habilitation services	Not Covered	Not Covered	Excluded service
	Skilled nursing care	Deductible and 20% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP. Skilled nursing care benefits are limited to 100 days per cause
	Durable medical equipment	Deductible and 20% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP.
	Hospice service	Deductible and 20% coinsurance	Deductible and 40% coinsurance	Requires precertification. Failure to obtain will result in penalty of 20% of MAP. Hospice service is limited to 6 months of service
If your child needs dental or eye care	Eye exam	$25 copay / visit	$50 copay / visit	Limited to 1 eye exam each year. Includes children and adults.
	Glasses	$100 hardware allowance per year	$100 hardware allowance per year	Limited to $100 per year. Includes children and adults.
	Dental check-up	Not Covered	Not Covered	Excluded Service

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic care	• Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-811-3298. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: For all issues except prescription drug issues, call the FirstCarolinaCare Insurance Co. Appeals and Grievance Coordinator, 800-574-8556. For prescription drug appeals and grievances, call the MedImpact Healthcare Systems Appeal Coordinator at 800-788-2949.

You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Additionally, a state consumer assistance program may be able to help you: http://www.ncdoi.com/Smart/
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
877-885-0231 (toll free)/ 919-807-6860/ 919-807-6865 (fax)

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

Amount owed to providers:	$7,540
Plan pays	$5,690
Patient pays	$1,850

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Co-pays	$40
Co-insurance	$690
Limits or exclusions	$120
Total	**$1,850**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers:	$5,400
Plan pays	$4,470
Patient pays	$930

Sample care costs:

Prescriptions	$2,900
Medical equipment & supplies	$1,300
Office visits & procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$570
Co-insurance	$280
Limits or exclusions	$80
Total	**$930**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.