North Carolina Dental Society Healthcare Plan: Plan B

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual, Family | **Plan Type:** PPO

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.myhealthplanonline.com or by calling 1-877-900-6237.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,000 person/$3,000 family Doesn't apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over at the beginning of each coverage period. 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?	Yes. $250 per confinement **deductible** for out-of-network hospital services. 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.
Is there an out–of–pocket limit on my expenses?	In-Network: $3,000 person/$6,000 family Out-of-Network: $6,000 person/$12,000 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, balance-billed charges, deductibles and health care 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?	Yes, $2,000,000.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. 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 in-network medical **providers** visit www.medcost.com or call 800-824-7406. For a list of in-network Caremark pharmacies visit www.caremark.com or call 800-552-8159.	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 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 5. 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 encourages you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	In-network Provider	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	$30 co-pay/visit	40% coinsurance	The office visit **co-pay** does not apply to prescription drugs, cancer treatments and physical, speech and occupational therapy. These services are subject to the plan **deductible** and **coinsurance** requirement and the plan's exclusions and limitations.
	Specialist visit	30% coinsurance	40% coinsurance	
	Other practitioner office visit	Not covered	Not covered	
	Preventive care/screening/immunization	No charge	No coverage, except mandated benefits	
If you have a test	Diagnostic test (x-ray, blood work)	$30 co-pay/visit if billed separately from the office visit	40% coinsurance	------------------None-------------------
	Imaging (CT/PET scans, MRIs)	$30 co-pay/visit if billed separately from the office visit	40% coinsurance	Precertification required

Common Medical Event	Services You May Need	In-network Provider	Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or (866)-905-6237.	Generic drugs	$10 co-pay for mail order of 32-90 day supply; $5 co-pay for retail, max. 31-day supply	No benefits paid outside of the Caremark Network	If your physician indicates a generic drug can be dispensed and you request a brand name drug, you will pay the applicable **co-pay** for the brand prescription, plus 100% of the difference in retail cost between the generic and the brand name drug. Certain prescriptions must be filled through the Caremark Specialty Pharmacy as described at www.caremark.com.
	Formulary brand drugs	$60 co-pay for mail order of 32-90 day supply; $30 co-pay for retail, max. 31-day supply		
	Non-formulary brand drugs	$100 co-pay for mail order of 32-90 day supply; $50 co-pay for retail, max. 31-day supply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	$250 charge for failure to obtain pre-certification for certain hospital admissions and outpatient procedures.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	The **deductible** is waived for the initial emergency room treatment of an accidental injury, provided the services are rendered within 72 hours of the accident causing the injury.
	Emergency medical transportation	30% coinsurance	30% coinsurance	-----------------None------------------
	Urgent care	30% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	$250 charge for failure to obtain pre-certification for certain hospital admissions and outpatient procedures.
	Physician/surgeon fee	30% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	In-network Provider	Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% coinsurance	40% coinsurance	$250 charge for failure to obtain pre-certification for certain hospital admissions and outpatient procedures.
	Mental/Behavioral health inpatient services			
	Substance use disorder outpatient services			
	Substance use disorder inpatient services			
If you are pregnant	Prenatal and postnatal care	30% coinsurance	40% coinsurance	------------------None------------------
	Delivery and all inpatient services			
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	------------------None------------------
	Rehabilitation services (physical, speech or occupational therapy)	30% coinsurance	40% coinsurance	------------------None------------------
	Chiropractic care	30% coinsurance	40% coinsurance	------------------None------------------
	Skilled nursing care	30% coinsurance	40% coinsurance	Patient must be confined within 14 days after discharge from a hospital where he was confined for at least 3 successive days.
	Durable medical equipment	30% coinsurance	40% coinsurance	Subject to an annual maximum of $6,000
	Hospice service	30% coinsurance	40% coinsurance	------------------None------------------
If you need dental or eye care	Eye exam	Not covered	Not covered	------------------None------------------
	Glasses	Not covered	Not covered	------------------None------------------
	Dental check-up	Not covered	Not covered	------------------None------------------

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids (adult)
- Infertility treatment
- Long-term care
- Routine eye care (adult)
- 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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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 apply.

For more information on your rights to continue coverage, contact the plan at (877) 900-6237. 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 x.61565 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 the Claims Administrator, Interactive Medical Systems, P.O. Box 1349, Wake Forest, NC 27588, (877) 900-6237.

––––––––––––––––––––––*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** $4,390
- **Patient pays** $3,150

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
Copays	$290
Coinsurance	$1,710
Limits or exclusions	$150
Total	**$3,150**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,700
- **Patient pays** $2,700

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:*

Deductibles	$1,000
Copays	$400
Coinsurance	$1,220
Limits or exclusions	$80
Total	**$2,700**

*Cost sharing provisions are based on the deductibles and out of pocket limits for the single/self-only coverage tier.

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?

û **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?

û **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?

ü **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?

ü **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.