NC Bar Association Health Benefit Trust: Plan 2

Coverage Period: 10/01/2016 - 09/30/2017

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.bcbsnc.com or by calling 1-877-275-9787.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network- **$1,000** Individual/**$2,000** Family Total. Out-of-Network- **$2,000** Individual/**$4,000** Family Total. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to 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. In-Network- **$3,000** Individual/**$6,000** Family Total. Out-of-Network- **$6,000** Individual/ **$12,000** Family Total.	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, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services	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.	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 *specific* coverage limits, such as limits on the number of office visits.

Questions: Call 1-877-275-9787 or visit us at www.bcbsnc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-275-9787 to request a copy.

Does this plan use a network of providers?	Yes. For a list of In-Network providers, see www.bcbsnc.com/content/providersearch/index.htm or please call 1-877-275-9787	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 a later page. 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 in-network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit	30% Coinsurance	---none---
	Specialist visit	$50/visit	30% Coinsurance	---none---

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Other practitioner office visit	$50/Chiropractic Visit	30% Coinsurance/ Chiropractic Visit	-Coverage is limited to 30 visits for Chiropractic care.
	Federally Mandated Preventive care/screening/immunization	No Charge	Not Covered	-Limits may apply
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	30% Coinsurance	-No coverage for tests not ordered by a doctor.
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	30% Coinsurance	-Prior authorization may be required for benefits to be provided
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://host1.medcohealth.com/consumer/site/openenrollment?accessCode=NATPLSNAPRF14&pageName=oeinfo	Generic drugs	$10 / 30 day supply	Copayment + charge over In-Network Allowed Amount	$30 / 90 day supply
	Preferred brand drugs	$35 / 30 day supply	Copayment + charge over In-Network Allowed Amount	$105 / 90 day supply
	Non-preferred brand drugs	$55 / 30 day supply	Copayment + charge over In-Network Allowed Amount	$165 / 90 day supply No coverage for drugs in excess of quantity limits or therapeutically equivalent to an over the counter drug
	Specialty drugs	25% Coinsurance	Coinsurance + charge over In-Network Allowed Amount	- You pay up to $150 maximum - 30 day supply limit
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	30% Coinsurance	---none---
	Physician/surgeon fees	10% Coinsurance	30% Coinsurance	---none---

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need immediate medical attention	Emergency room services	$250/visit	$250/visit	---none---
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	---none---
	Urgent care	$50/visit	$50/visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	30% Coinsurance	-Precertification may be required
	Physician/surgeon fee	10% Coinsurance	30% Coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50/office visit; 10% Coinsurance/ outpatient	30% Coinsurance/ outpatient	-Prior Authorization may be required
	Mental/Behavioral health inpatient services	10% Coinsurance	30% Coinsurance	-Precertification required
	Substance use disorder outpatient services	$50/office visit; 10% Coinsurance/ outpatient	30% Coinsurance/ outpatient	-Prior Authorization may be required
	Substance use disorder inpatient services	10% Coinsurance	30% Coinsurance	-Precertification required
If you are pregnant	Prenatal and postnatal care	10% Coinsurance	30% Coinsurance	-No coverage for maternity for dependent children.
	Delivery and all inpatient services	10% Coinsurance	30% Coinsurance	-Precertification may be required
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	30% Coinsurance	-Prior authorization may be required for benefits to be provided

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs other special health needs	Rehabilitation services	$50 / office visit; 10% Coinsurance	30% Coinsurance	-Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic and 30 visits per benefit period for Speech Therapy - $40,000 maximum per benefit period for Adaptive Behavior Treatment for members ages 18 and younger.
	Habilitation services	$50 / office visit; 10% Coinsurance	30% Coinsurance	-Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic and 30 visits per benefit period for Speech Therapy - $40,000 maximum per benefit period for Adaptive Behavior Treatment for members ages 18 and younger.
	Skilled nursing care	10% Coinsurance	30% Coinsurance	-Coverage is limited to 60 days per benefit period.-Precertification required
	Durable medical equipment	10% Coinsurance	30% Coinsurance	-Prior authorization may be required for benefits to be provided-Limits may apply
	Hospice services	10% Coinsurance	30% Coinsurance	-Precertification may be required

Common Medical Event	Services You May Need	Your cost* if you use a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If your child needs dental or eye care	Routine eye exam	No Charge	Not Covered	-Limits may apply
	Glasses	Not Covered	Not Covered	Excluded Service
	Dental check-up	Not Covered	Not Covered	Excluded Service

*HSA/HRA funds, if available, may be used to cover eligible medical expenses

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 and services
- Dental care (Adult)
- Long-term care, respite care, rest cures
- Routine Foot Care
- Weight loss programs

*HSA/HRA funds, if available, may be used to cover eligible medical expenses
**Self-funded groups may cover this service; check your benefit booklet for details

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
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S. (PPO). Coverage provided outside the United States. See www.bcbsnc.com
- Private duty nursing
- Routine eye care

***Self-funded groups may not cover this service; check your benefit booklet for details

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 BCBSNC at 1-877-275-9787. 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: BCBSNC at 1-877-275-9787 or **mybcbsnc.com**. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, if applicable.

Does This Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does This Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of health plan. **The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.**

*Please note that although amounts contributed by an employer to an employee's HSA or integrated HRA should be taken into account for this calculation, the amount of that contribution, if unknown, has not been considered.

Language Access Services:

Spanish (Español): Para obtener asistencia en español, llame al número que aparece al respaldo de su tarjeta del seguro.
Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.
Chinese (中文):如需國語或廣東話協助，請致電您保險卡背面的電話號碼。
Navajo (Dine):Diné bizaad bee shíká'adoowoł nínzingo kwojį' hólne', naaltsoos áłts'ísí nantinígíí bine'dęę' binámboo bikáá'.

----------*To see examples 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 also will 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** $5,740
- **You pay** $1,800

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	$30
Coinsurance	$600
Limits or exclusions	$200
Total	**$1,800**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,300
- **You pay** $1,100

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	$600
Copays	$300
Coinsurance	$100
Limits or exclusions	$80
Total	**$1,100**

Questions and answers about 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.
- 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 for 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 consider also 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.