
 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 1-828-281-9000 or visit us at www.ntca.org. 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 www.ntca.org or call 1-828-281-9000 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0 <u>In-Network</u> \$200 per individual/\$400 per family – <u>Out-of-Network</u>	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 the <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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. All <u>in-network</u> services and <u>emergency services</u> whether <u>in-network</u> or <u>out-of-network</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</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/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$2,500 per individual/\$5,000 per family for <u>Out-of-Network</u> medical \$1,850 per individual/\$3,700 per family– <u>prescription drug</u>	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 limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Deductibles</u> , <u>premiums</u> , <u>balanced-billed</u> charges, health care this <u>plan</u> doesn't cover, charges in excess of any benefit and payment limits, and the cost of certain <u>specialty drugs</u> that are considered non-essential health benefits.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.ntca.org/UnitedHealthcare or call 1-800-860-5203 for a list of <u>network providers</u> .	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 provider 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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	30% <u>coinsurance</u>	General Medicine visits through Teladoc will require payment of \$49 at the time of service. The claim will then process under the primary care office visit benefits and you will be reimbursed the difference, if any, between \$49 and your Primary Care Physician office visit responsibility under the medical plan.
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit	30% <u>coinsurance</u>	Dermatology visits through Teladoc will require payment of \$85 at the time of service. Claims through Teladoc will process under the specialist office visit benefits and you will be reimbursed the difference between the payment and your specialist office visit responsibility under the medical plan.
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge	30% <u>coinsurance</u>	Precertification is required to show the procedure is <u>medically necessary</u> .
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com	Generic drugs	\$12 <u>copay</u> (retail) \$25 <u>copay</u> (mail order)		Limited to a 30-day supply (retail); 31-90 day supply (mail order). The Smart90 program allows you to receive a 90-day supply of eligible prescriptions from a designated retail pharmacy and pay the applicable mail order <u>copay</u> . Certain <u>prescription drugs</u> require <u>preauthorization</u> , are subject to drug utilization rules including step
	Preferred brand drugs	\$35 <u>copay</u> (retail) \$85 <u>copay</u> (mail order)		
	Non-preferred brand drugs	\$60 <u>copay</u> (retail) \$150 <u>copay</u> (mail order)		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				therapy and may only be dispensed by mail. If a generic drug is available, only cost of generic is covered. Fertility drugs payable at 50% of medication cost. Compound drugs are covered only if <u>medically necessary</u> and clinically appropriate. Some drugs are excluded from coverage.
	<u>Specialty drugs</u>	Generic - \$25 <u>copay</u> Preferred - \$85 <u>copay</u> Non-preferred - \$150 <u>copay</u>		Limited to Accredo specialty mail order only. Please see "Important Questions" for information regarding <u>specialty drugs</u> and the plan's <u>out-of-pocket limit</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% <u>coinsurance</u>	For hysterectomy and laminectomy - precertification is required to show the procedure is <u>medically necessary</u>
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	Assistant surgeon fees are based on the assistant surgeon's negotiated rate or <u>Usual, Customary and Reasonable</u> charges for assistant surgeon services if no negotiated rate.
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay/visit</u>	\$50 <u>copay/visit</u>	None
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$40 <u>copay</u>	\$40 <u>copay</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% <u>coinsurance</u>	Preadmission review required to ensure a stay is not denied due to lack of medical necessity.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	Assistant surgeon fees are based on the assistant surgeon's negotiated rate or <u>Usual, Customary and Reasonable</u> charges for assistant surgeon services if no negotiated rate. Coverage for transplants is limited to one per single organ or bone marrow per lifetime.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> if billed as office visit and no charge for other outpatient services	30% <u>coinsurance</u>	Behavioral health services through Teladoc will require payment of \$220 for the initial visit, \$100 for ongoing psychiatrist visit or \$90 for non-psychiatrist visit. The claim will then process under the Mental Health Provider Outpatient benefits and you will be reimbursed the difference, if any, between the payment and your Mental Health Provider Outpatient responsibility under the medical plan.
	Inpatient services	No charge	30% <u>coinsurance</u>	Preadmission review required to ensure stay is not denied due to lack of medical necessity.
If you are pregnant	Office visits	\$20 <u>copay</u> /visit	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Notification upon admission is required.
	Childbirth/delivery professional services	No Charge	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No Charge	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	Limited to 50 visits per calendar year
	<u>Rehabilitation services</u>	\$20 <u>copay</u> if billed as office visit for physical therapy and no charge for other rehabilitation services	30% <u>coinsurance</u>	Physical, occupational and speech therapy benefits are subject to medical review.
	<u>Habilitation services</u>	\$20 <u>copay</u> if billed as office visit for physical therapy and no charge for other rehabilitation services	30% <u>coinsurance</u>	Physical, occupational and speech therapy benefits are subject to medical review.
	<u>Skilled nursing care</u>	No charge	30% <u>coinsurance</u>	Limited to 30 days per calendar year. You may be subject to any charges above the <u>Usual, Customary, and Reasonable (UCR)</u> amount.
	<u>Durable medical equipment</u>	No charge	30% <u>coinsurance</u>	Repair or replacement will not be covered during the equipment's normal, useful life unless the equipment is damaged in the course of normal use. <u>DME</u> with a billed or <u>UCR</u> purchase price of

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				less than \$1,000 covered up to the purchase price with no rental. <u>DME</u> with a billed or <u>UCR</u> charge \$1,000 or greater covered up to the purchase price as a rental arrangement, and precertification is required to show the <u>DME</u> is <u>medically necessary</u> . You may be subject to any charges above the <u>Usual, Customary, and Reasonable (UCR)</u> amount.
	<u>Hospice services</u>	No charge	30% <u>coinsurance</u>	Limited to six months of treatment. Preadmission review required to ensure inpatient services are not denied due to lack of medical necessity.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	If adopted by Member Company, 1 routine exam per calendar year for children under age 19. You may be subject to any charges above the <u>Usual, Customary, and Reasonable (UCR)</u> amount.
	Children's glasses	No charge	No charge	For children under age 19, one pair of eyeglass lenses per calendar year. In addition, for children under age 19: (1) if adopted by Member Company, eyeglass frames with an allowance of \$140 OR contact lenses with an allowance of \$150 per calendar year; or (2) under the medical benefit, for eyeglass frames or contact lenses, 100% of the lesser of the negotiated rate or billed chart not to exceed a maximum payment of \$150 per calendar year.
	Children's dental check-up	Not covered	Not covered	Covered under separate dental plan if adopted by Member Company.

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental Care (Adult) – except limited coverage related to accidents, and participants and dependents age 9 and older when anesthesia is medically necessary because of a demonstrated non-dental physical or cognitive impairment.
- Dental check-up (Child) – covered under separate dental plan if adopted by Member Company.
- Long-term care
- Weight loss programs

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

- Acupuncture – Maximum payment \$50/visit, 20-visit limit and \$1,000 annual maximum payment per calendar year; limited to treatment for an injury or illness coverage by the NTCA GHP.
- Chiropractic Care – Maximum payment \$50/visit, 1 visit per day limit, 30-visit per calendar year limit.
- Hearing aids – Maximum 3 hearing aid devices every 4 calendar years. \$6,250 in-network and \$4,375 out-of-network maximum payment every 4 calendar years.
- Infertility treatment is excluded except for artificial insemination, In-vitro fertilization and similar procedures
- Non-emergency care when traveling outside the U.S. Contact 1-828-281-9000 for additional information on covered services.
- Private duty nursing – 30 days per calendar year visit limit following discharge
- Routine eye care (Adult) - If adopted by Member Company, \$100 annual maximum payment, 1 routine exam per calendar year. \$100 annual maximum payment does not apply to anyone under age 19.
- Routine foot care

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-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: NTCA Group Health Program at 1-828-281-9000 or U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-828-281-9000.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-828-281-9000.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-828-281-9000.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-828-281-9000.

----- *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 \$0
- Specialist copayment \$20
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$70

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$0
- Specialist copayment \$20
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

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

- The plan's overall deductible \$0
- Specialist copayment \$20
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$25
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$25