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 deductible?	$0 In-Network $500 per individual/$1,500 per family – Out-of-Network	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.
Are there services covered before you meet your deductible?	Yes. All in-network services and emergency services whether in-network or out-of-network.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,000 per individual/$6,000 per family for In-network medical; $3,000 per individual/$9,000 per family for Out-of-Network medical $1,850 per individual/$3,700 per family– prescription drug	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?	Deductibles, premiums, balanced-billed charges, health care this plan doesn't cover, charges in excess of any benefit and payment limits, and the cost of certain specialty drugs that are considered non-essential health benefits.	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.ntca.org/UnitedHealthcare or call 1-800-860-5203 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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	40% coinsurance	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.
	Specialist visit	$30 copay/visit	40% coinsurance	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.
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance*	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance*	Precertification is required to show the procedure is medically necessary.

*When required by ERISA, the amount to which coinsurance will be applied and your responsibility calculated will be based on ERISA's surprise billing rules. For more information, see the Summary Plan Description (Section III, Medical and Dental Benefits).

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$12 copay (retail) $25 copay (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 copay. Certain prescription drugs require preauthorization, are subject to drug utilization rules including step 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 up to a lifetime maximum of $10,000. Compound drugs are covered only if medically necessary and clinically appropriate. Some drugs are excluded from coverage.
	Preferred brand drugs	$35 copay (retail) $85 copay (mail order)		
	Non-preferred brand drugs	$60 copay (retail) $150 copay (mail order)		
	Specialty drugs	Generic - $25 copay Preferred - $85 copay Non-preferred - $150 copay		Limited to Accredo specialty mail order only Please see "Important Questions" for information regarding specialty drugs and the plan's out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance*	For hysterectomy and laminectomy - precertification is required to show the procedure is medically necessary.
	Physician/surgeon fees	20% coinsurance	40% coinsurance*	Assistant surgeon fees are based on the assistant surgeon's negotiated rate or Usual, Customary and Reasonable charges for assistant surgeon services if no negotiated rate.*
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance*	None
	Emergency medical transportation	20% coinsurance	20% coinsurance*	None
	Urgent care	$60 copay	$60 copay*	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance*	Preadmission review required to ensure a stay is not denied due to lack of medical necessity.
	Physician/surgeon fees	20% coinsurance	40% coinsurance*	Assistant surgeon fees are based on the assistant surgeon's negotiated rate or Usual, Customary

*When required by ERISA, the amount to which coinsurance will be applied and your responsibility calculated will be based on ERISA's surprise billing rules. For more information, see the Summary Plan Description (Section III, Medical and Dental Benefits).

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)	
				and Reasonable charges for assistant surgeon services if no negotiated rate.* Coverage for transplants is limited to one per single organ or bone marrow per lifetime.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay if billed as office visit and 20% coinsurance for other outpatient services	40% coinsurance	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	20% coinsurance	40% coinsurance*	Preadmission review required to ensure stay is not denied due to lack of medical necessity.
If you are pregnant	Office visits	$30 copay/visit	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance 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	20% coinsurance	40% coinsurance*	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance*	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 50 visits per calendar year
	Rehabilitation services	$30 copay if billed as office visit for physical therapy and 20% coinsurance for other rehabilitation services	40% coinsurance*	After 10 physical and occupational therapy visits (combined) medical review is required. All speech therapy benefits are subject to medical review.
	Habilitation services	$30 copay if billed as office visit for physical therapy and 20% coinsurance for other rehabilitation services	40% coinsurance*	After 10 physical and occupational therapy visits (combined) medical review is required. All speech therapy benefits are subject to medical review.
	Skilled nursing care	20% coinsurance	40% coinsurance*	Limited to 30 days per calendar year.

*When required by ERISA, the amount to which coinsurance will be applied and your responsibility calculated will be based on ERISA's surprise billing rules. For more information, see the Summary Plan Description (Section III, Medical and Dental Benefits).

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)	
	Durable medical equipment	20% coinsurance	40% coinsurance	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. DME with a billed or UCR purchase price of less than $1,000 covered up to the purchase price with no rental. DME with a billed or UCR charge $1,000 or greater covered up to the purchase price as a rental arrangement, and precertification is required to show the DME is medically necessary.
	Hospice services	20% coinsurance	40% coinsurance*	Limited to six months of treatment (nine months if the provider recertifies you or your dependent remains terminally ill after 6 months). 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	40% coinsurance	40% coinsurance	If adopted by Member Company, one routine exam per calendar year for children under age 19. You may be subject to any charges above the Usual, Customary, and Reasonable (UCR) amount.
	Children's glasses	40% coinsurance	40% coinsurance	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 $180 OR contact lenses with an allowance of $180 per calendar year; or (2) under the medical benefit, for eyeglass frames or contact lenses, 60% 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.

*When required by ERISA, the amount to which coinsurance will be applied and your responsibility calculated will be based on ERISA's surprise billing rules. For more information, see the Summary Plan Description (Section III, Medical and Dental Benefits).

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, unless through the Real Appeal weight loss program.

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

- Acupuncture – Maximum benefit $50/visit, 20-visit limit and $1,000 annual maximum benefit per calendar year; limited to treatment for an injury or illness coverage by the NTCA GHP.
- Chiropractic Care – Maximum benefit $50/visit, 1 visit per day limit, 30-visit per calendar year limit.
- Hearing aids – Maximum 3 prescription hearing aids every 4 calendar years. $5,000 maximum benefit every 4 calendar years.
- Infertility treatment including artificial insemination, in-vitro fertilization, and similar procedures up to a lifetime limit of $20,000; infertility drugs payable at 50% of medication cost up to a lifetime limit of $10,000.
- 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 benefit, 1 routine exam per calendar year. $100 annual maximum benefit 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.

*When required by ERISA, the amount to which coinsurance will be applied and your responsibility calculated will be based on ERISA's surprise billing rules. For more information, see the Summary Plan Description (Section III, Medical and Dental Benefits).

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, kwiijigo holne' 1-828-281-9000.

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

*When required by ERISA, the amount to which coinsurance will be applied and your responsibility calculated will be based on ERISA's surprise billing rules. For more information, see the Summary Plan Description (Section III, Medical and Dental Benefits).

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	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,570**

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	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$20
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,240**

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

The plan's overall deductible	**$0**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$35
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$535**

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